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# The Medical Patient

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In selecting this subject: "The Medical Patient", I did so with the hope that I might be able to arouse more enthusiasm and a better understanding of the problems which arise in the nursing care of this class of patients. I have not infrequently heard nurses make the remark "It is only a medical patient." Unfortunately for everyone this same attitude is to be found also among medical students, internes and even many practitioners of medicine. While one must admit that surgery is a much more dramatic field and that end-results are seen in a comparatively short time, it is generally accepted among our professions that more thought, tact and skill are required in the successful handling of the medical patients, especially the so-called neurotics. To discuss or even to mention the various organic problems in the nursing care of the medical patient is outside the realms of this paper. Here we will limit ourselves to the less discussed and less understood psychological aspects of the medical patient and the medical nurse.

Internal medicine is the term used to designate the wide field of medical practice which remains after the separation of surgery, obstetrics, and gynaecology. Clinical medicine, in its broadest sense, means that part of medicine which has to deal with the bedside investigation of disease in the living body. Progress in medicine is not hedged about by fixed limits but may extend as far as the individual's methods of observation and investigation can carry him. The nurse, as well as the medical student, should realise this fact early in her course of study. The bedside study of a case should begin with a carefully taken history and should not end until every organ in the body has been thoroughly examined.

With the growth of clinical medicine have come all the influences of physiology, bacteriology, physiological chemistry and various laboratory and mechanical aids to the diagnosis, all designed to supplement clinical diagnosis, yet many of them serving as dangerous lures for the unwary student of bedside medicine. When a laboratory report is received it should not be given unwarranted weight in the diagnosis but its value must be checked against the clinical findings and if these do not correlate with each other then we must go back and study the case and check the laboratory report carefully for the error.

The "primal sympathy of man for man" which gave rise to nursing and to medicine is being threatened by these various diagnostic and therapeutic agencies which through spectacular appeal or a promise of a short cut tend to draw the student away from the bedside. The need for a sympathetic understanding of the patients, both by the nurses and doctors, is as necessary today as in the past. The nurse and the doctor must cultivate the art of their professions, their manner must be such as to inspire confidence and hope, and yet "the seeing eye, the hearing ear, and the understanding mind" must be employed with such a critical outlook that they approach the accuracy of a science. With these qualifications one is on the threshold of acquainting himself or her-

self with the most intricate and the most interesting unit of society, the human organism. One must learn that intuitive sagacity is synonymous with hard discipline and that everyone is endowed with special senses, which, if properly trained, will become powerful instruments in precision, incredibly keen and penetrating in the search for knowledge.

Now let us consider four of the chief factors which influence our patients' conduct, namely — dissociations, complexes, conflicts and repressions. Dissociation of consciousness is the division of the mind into independent fragments which are not co-ordinated together to attain some common end. This dissociation may be only temporary and partial in character, as seen in some individuals who ply their trade while continuing to think of other things, or may be complete, as seen in automatic writing and double personality, the former playing a large part in spiritualism, the latter furnishing fascinating material for books like "Dr. Jekyll and Mr. Hyde." This dissociation is very common and perhaps an inevitable occurrence in the psychology of every human being. Our political and religious convictions are notoriously inaccessible to argument, and we preserve the traditional beliefs of childhood in spite of the contradictory facts constantly presented by our experience. These phenomena are precisely similar in kind to the dissociation which permits the asylum queen to scrub floors, serenely unconscious of the incongruity between her exalted rank and her mental occupation.

A hobby is a complex: it is a system of connected ideas, with a strong emotional tone and a tendency to produce actions of a certain definite character. Consider, for example, the immensely powerful complex formed in a young woman or man who has recently fallen in love. Ideas belonging to the complex incessantly emerge into consciousness, the slightest associative connection sufficing to arouse them and causing all of her mental energy to be absorbed in weaving trains of thought centred in the beloved one, and thus she becomes unable to concentrate her mind in the business of the day. Even in the world of science, which the ignorant generally regard as a peculiar sphere of dispassionate and cold thought, complexes play a vast role.

When an individual is called upon to consider a new measure his decisions are largely determined by a certain system of ideas and trends of thought peculiar to himself, and of which he may be totally unaware, since he is of the opinion that his deductions are formed solely from the pros and cons of the subject matter before him. This process of self-deception, in which the individual conceals the real foundation of his thought by a series of adventitious props, is called "Rationalisation." The prevalence of rationalisation is responsible for the erroneous belief that reason, taken in the sense of logical deduction from given premises, plays the dominating role in the formation of human thought and conduct. On the contrary, thought or action makes its appearance without any antecedent process, and is moulded from the various complexes resulting from our instinct and experience. "Reason" is a manifestation of a desire to satisfy our "ego." Most cases where sudden passion over some trifle is witnessed, as is often seen in patients, may be explained along the lines of complexes.

Delusions shown by our patients are not such grotesque and baseless anomalies if we cease to take them at their face value and delve instead into the deeper strata and

workings of the patient's mind. If a complex is out of harmony with the mind as a whole a struggle or "conflict" arises between this complex and the personality. This state of conflict is characterised by a conduct on an unpleasant emotional tension; the individual feels himself torn between two lines of conduct, neither of which is possible on account of the resistance offered by the other. Conflict, with its emotional tension and accompanying indecision and paralysis of action cannot persist indefinitely; it is necessary to find some way out of the impasse. If the individual comprehends the forces at war within himself and deliberately adopts a selected line of conduct which is the rational or ideal solution of a conflict, the war is over.

Other methods used to avoid the conflict are dissociation of consciousness and repressions. It is in solving these conflicts that the patient frequently develops a nervous exhaustion or a neurosis. In the mechanism of repressions as an escape from the conflict, one of the opponents is banished from consciousness and no longer is allowed to achieve its normal expression. This method of attaining peace of mind by refusing to acknowledge to ourselves the existence of unpleasant facts which would otherwise grievously disquiet us is familiar to us all. When we are considering the patient his psychological reactions must be duly delved into, studied and explained on a satisfactory basis. Often marvellous results in the treatment of the patient are due merely to an adequate explanation of his own reactions, showing him a way out from the conflicts in his life.

When we are considering the sick patient, especially the medical case, we must not think of him only from the physical side, but must explore psychological reactions to his disease and to life in general, since the latter is often the more important factor in establishing the equanimity and the satisfaction of the individual who is lying on his sick bed or perhaps his death bed. The patient's psychological reactions can manifest certain powers and modes of expression which may act as powerful allies or as damaging enemies of his health. Man is tremendously affected by his environment — some individuals can readily adapt themselves to changes in their physical conditions and future outlook in life, but to the majority of us, if we are faced with the stern realities of being a patient and the uncertainties of the prognosis in disease, we lose our equanimity or mental balance.

The nurse's privilege and duty is to recognise the trend of her patient's mental workings and deftly and unobtrusively to encourage the recognition of the facts by the patient as things which are to be faced—not as "stumbling blocks—but as stepping stones" towards health. The sympathetic and understanding nurse can actively help her charge, one step at a time, toward adaptation to the new environment, remembering that many of the patients, especially the discouraged and depressed, cannot be incited to effort by simply having the promise of health held out to them, but are only capable of living in the immediate present with a skeptical outlook for the future.

Almost all patients are hypersuggestible, which may be either the nurse's despair or her hope. The nurse must remember that her way of giving treatment, her expression, or her very presence, become potent stimuli to the patient's suggestion. If she realises this fact, she can utilise it to the advantage of the patient by

making these stimuli wholesome. The nurse, with sympathetic understanding of her charge and unswerving loyalty to orders, can carry out instructions, even if unpleasant, with the average patient so as to produce a satisfactory emotional response: one of co-operation and faith. In some individuals, where ordinary persuasion or requests fail, the nurse, in accordance with the doctor's orders and with the idea of helping the patient back to health, may have to use force which can itself act as a powerful stimulus to suggestion. Force, unwisely or unkindly used, produces a damaging effect, causing reactions of fear or anger, even leading to ideas of persecution and increased resistance in the patient. The patient's attitude, if he is suggestible, largely depends on the nurse who can make his illness a calamity by fear-breeding or suspicion-forming suggestion, which may have their origin in the nurse's own outlook on life and people. The happier, truer and more wholesome the nurse's life, the better she is equipped to practise the art of nursing. She must not show a patient hollow cheerfulness, which any patient knows is assumed for his benefit and which thus acts as an aggravating, irritating stimulus.

Another means of helping her patient is to divert and interest him in things outside of himself and even the hospital, as reference to books, to current events, to sports, but never to the gruesome events which take place within any hospital. If the nurse can successfully distract the patient's attention and lead his thoughts along these channels she has accomplished much in the way of treatment. Most of the patients have many habits of complaining, impatience, despair and loss of emotional control, which retard recovery of the body and produce a mental attitude not conducive to health, and it is the nurse's duty to provide incentive to cheerfulness, optimism, and enthusiasm for the future. The nurse must be on guard against paving the way to invalidism, to which all patients are prone since it is the way of least resistance, and she must build up an endurance in the patient by encouraging him to pay little attention to minor ailments. Determination, hope, confidence and the "will to live" are powerful influences, when l i f e hangs in the balance, and also during the period of convalescence.

The neurotic patient offers many interesting and varied reactions to the struggle for existence: these neurotic manifestations are put forward by these patients as a means of avoiding the realities of life. It is in their attempt to escape, to obtain sympathy from parents, husbands or wives, or in their feeling of utter hopelessness in a struggle which has been too much for them, that we see them defeated, discouraged and seemingly helpless to carry on. Here, more than in any other field of medicine, we must assume an interested fellow-feeling, without becoming too intimate or showing too much sympathy towards them.

Almost everyone of us has certain neurotic tendencies in our personality which would be accentuated to the degree of a neurosis if we were forced to acknowledge defeat in our struggle for existence. Thus, we find that the depression and increased difficulties in modern civilisation have precipitated more individuals to the point of a neurosis. These neurotic patients may be looked upon as weaker sisters in the psychological realm, although they may be very outstanding students. Disagreeable home environment, unsatisfied sexual impulses, inferiority complexes, especially in the psycho-biological inferior type, are the principal pre-

cipitating etiological points in the neurosis—it is an expression of failure to adapt oneself to living conditions or a way to escape from this intolerable struggle. The management of the neurotic presents at once the most difficult and the most hopeful problem in the whole realm of neurology. While few are curable, all these patients can be helped, provided that they are treated honestly and intelligently. In no branch of medicine do the nurses and doctors require so much tact, art, skill, knowledge and understanding as in the treatment of the neurosis. To be successful, treatment must be directed to each individual problem of the patient, taking each up independently and discussing it in a free, unpretentious manner. The patient must feel "at home", must have confidence and a feeling that he is being understood by those who are caring for him.

To attain this end, the nurse must train her mind in accuracy of perception, concentration, equanimity and automatic habits which are all extremely important in the accomplishment of the highest in her profession. All have natural ability along these lines which must be studied and trained by the individual herself in order to develop these talents so that she can do her best.

Keen accurate perception of the patient with full notes on his chart are of great value to the attending physician. The nurse should act in the capacity of an observer and recorder of facts which occur during the time that she is on duty, but she should never attempt to interpret her observations when recording them. It is the duty of the physician, and not of the nurse, to sum up, to evaluate and to come to conclusions from the facts at hand.

The nurse, during her time on the wards, should train herself to observe the small details, such as the arrangement of the wards, the condition of the linens, the floors, the windows and most important of all, the expressions of the patients. Learning to look closely at the patient's face, instead of casually glancing at her when you care for her, makes it possible to note changes of expression, heightened colour, dilated pupils or evidences of emotional upset. Concentration can be acquired. The nurse should practise this with each patient she handles. William James advocates for memory training, and for improvement of our thinking processes, that we pay more and keener attention, which will arouse interest in the things to be remembered, and this, coupled with reputation, will assure a good working memory.

No quality of personality, in the nurse or physician, takes rank with imperturbability. Imperturbability means "coolness and presence of mind under all circumstances, calmness amid storms, clearness of judgment in moments of grave peril, immobility, impassiveness," or to use an old and expressive word, "phlegm." This quality which has been well developed in our profession is much appreciated by the laity—although misunderstood by them—and the nurse or doctor who is unfortunate enough to be without it, who betrays indecision and worry, and who shows that she or he is flustered in ordinary emergencies, quickly loses the confidence of the patient. This emotional balance, which refuses to allow feelings to obscure judgment by leading reason astray, is as necessary a safeguard for the nurse as for the physician. This can be acquired to a fair degree through education, practise and experience and, at the same time, without sacrificing the warmth of fellow-feeling. To secure a good natured equanimity we must not expect too much from people. We must deal

gently with this credulous human nature and restrain our indignation at the many petty offences which are caused by their whims, fancies and eccentricities, that are not entirely unlike our own.

There is no better opportunity for will-training than during a nurse's course of studies: the constant acting against desire, of doing tasks which in themselves cannot be agreeable, calls for a "will to do" and strengthens it. When she can accept hardship, drudgery, weariness of mind, body and soul, the nagging of uncooperative patients and the demands on her sympathies of the suffering, she has learned the art of making each circumstance a stepping stone to the mastery of herself and has accomplished the art of nursing. An individual's point of view determines his psychological reactions to his environment and his future outlook on life. Our points of view are frequently merely acquired prejudices, hence emotional rather than rational. Thus, to see the other man's views, one must fully study and comprehend the other's background and try to put herself in the other's "shoes," so to speak. This requires imagination.

Let us put ourselves in a patient's position, looking out from a tired mind and an aching body, after days of suffering, either physical or mental, and sleeplessness, and we, too, unless we are of an exceptional personality, would see the world as a dark, dreary place of torture, where one passes from failure to disaster, resulting in suffering and disgrace. The nurse who accepts and treats every patient as being like every other one will never be a great success, but she who studies the patient and learns his psychology will be a powerful therapeutic force to aid the physician in the treatment of the individual.

That a nurse is "born and not made" is probably especially true of the ideal medical nurse, although with a knowledge of psychology, any nurse can adapt herself and understand the patient. The medical nurse should be intensely interested in people as individuals, have a sympathetic understanding of the frailties and eccentricities of men and women with the ability to forgive them their weaknesses. She must have a personality, while domineering and strong, yet sweet and kind, so that she can lead the patient firmly yet gently back up the stepping stones to health. To have such a nurse with a medical patient, especially those with a definite mental twist or pscyhosis, probably means a cure which otherwise would be a failure.

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## THE INTERNATIONAL HOSPITAL CONGRESS

The Third International Hospital Congress takes place at Knocke sur Mer, Belgium, from June 28th to July 3rd, 1933.

A study trip for participants in the International Hospital Congress and the Congress of the International Council of Nurses has been arranged for from July 4th to 8th by the Dutch Hospital Association and the Dutch Nurses Association. The cost of this trip, which is inclusive and covers everything except liquid refreshments, will not exceed 75 guilders. The following cities will be visited: Rotterdam, The Hague, Leiden, Amsterdam and Alkmaar. Further information may be obtained from Dr. W. Alter, 2 Ernst Ludwig Allee, Buchschlag, Hessen, Germany.

# CANADIAN ARMY MEDICAL NURSING SERVICE

*At the annual dinner of the Toronto Unit of the Overseas Nursing Sisters' Association of Canada on November 18th, 1932, Major-General E. C. Ashton, C.M.G., V.D., Officer Commanding, Military District No. 2, as guest speaker gave a most interesting though brief résumé of the history of the Canadian Army Medical Service, which the* JOURNAL *is privileged to publish. The speaker acknowledged his gratitude to Sir Andrew McPhail for information and statistics obtained from "History of the Canadian Forces—Medical Services—*1914-1918."

Canada's Military Medical Service was established along lines similar to those of the Imperial Army and the first Director-General of Medical Services was an Imperial Officer (Colonel Neilson). The Canadian Army Medical Service really dates from the North-West Rebellion of 1885; in that year a few graduate nurses and religious sisters were employed in care of the sick and wounded in Western Canada. Four nurses proceeded with the troops of the first contingent to South Africa, returning about a year later when eight were sent over with the second contingent.

After the South African War, Captain Fiset (later Major-General Fiset), who had served with great gallantry in that war as a Regimental Medical Officer, was made D.G. M.S. in 1903. This officer really began the formation of a Permanent Army Medical Service and laid the foundations of the Canadian Army Medical Corps. He was specially trained at Aldershot for this purpose. General Guy Carleton Jones took over the appointment of D.G.M.S. in 1906 — took similar training at Aldershot—and threw great energy into the organisation and training of our young Military Medical Units.

Field ambulances, general and stationary hospitals and other medical units were formed. Many of the leaders of the medical profession offered their services, raised units and underwent special training in military organisation and administration. It is to these pioneers in this work that the credit is due for the sound foundations which were laid for the great expansion necessary when war came. A small Permanent Force Service was established, operating military hospitals in Halifax and Quebec, and generally looking after the Permanent Force Troops; they also acted as instructors for the Non-Permanent Units.

Fortunately for Canada, the organisation of the Canadian Army Medical Service had been laid on sound lines and, while small, was well advanced in training before the great call came. A matron and four nurses were permanently employed in the military hospitals and a reserve corps of military

nurses was formed with an establishment of 57 nursing sisters who were given the relative rank of lieutenant and were titled Nursing Sisters.

This, then, was the situation when war was declared, and on this foundation the great Nursing Service of the Canadian Army was erected. On August 7th, 1914, Matron Macdonald took over the administration of the Nursing Service at Ottawa. Thousands of nurses volunteered and with the 1st Contingent, two matrons and 99 nurses embarked on the Franconia on September 29th, 1914, for overseas service. Some of these nurses were assigned to Imperial Units and the balance were posted to Canadian Units.

On August 28th, 1917, the Overseas Nursing establishment was placed at 2,003 nurses—27 matrons with a reserve of 203—and there were 313 Canadian Nurses with the English Service. Therefore the nurses of Canada were not only able to meet all the demands of the rapidly expanding Canadian Medical Service but were also able to materially help out the Nursing Service of the Mother Country.

In March, 1918, there were 828 Canadian Nurses actually in France. At the time of the Armistice, Empire Nurses in France were grouped as follows—

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| United Kingdom ..... | 1,754 |
| Canada ..... | 682 |
| Australia ..... | 339 |
| South Africa ..... | 79 |
| New Zealand ..... | 34 |

In addition to those in France the large Canadian hospitals in the British Isles were kept fully supplied with nurses. The Canadian Military Medical Service provided for the care of 400,000 overseas troops by seventy Medical Units.

In due course, as war casualties began to return to Canada, a Nursing Service was developed to serve the hospitals in Canada, first formed under the Military Hospital Commission and later taken over in 1918 by the Military Medical Service. Sixty-five Medical Units were formed and nearly a quarter of a million patients were cared for. Overseas, and in Canada, accommodation was provided in Canadian Military Hospitals for nearly 50,000 beds. The total number of nurses taken on the strength of the Canadian Army Medical Service for the war was 2,854—with 2,411 overseas. This does not include the 229 qualified nurses with the Q.A.I.M.N.S., nor Red Cross and V.A.D.'s.

Never in the history of war was the sick or wounded soldier so well looked after. Never was he so efficiently cared for in the field, so rapidly evacuated and so well nursed to recovery. I have seen the wounded transported, and made comfortable, in clean wholesome beds in England, beyond the sound of the guns, within a few hours of the receipt of their injuries. Great as Canada's losses were, totalling over 56,000 deaths overseas, they would have been much larger but for the skill and devotion of the Medical and Nursing Service, which was so highly praised by Sir Douglas Haig and Sir Arthur Currie.

Throughout the war the efforts of the Medical Service were rewarded by a very low sick rate. Hygiene precautions and anti-typhoid inoculation (and later T.A.B. inoculation) relieved all ranks of one of the greatest scourges of previous wars. Dysentery was unknown on the Western Front; cerebro-spinal meningitis was efficiently dealt with; new conditions such as trench fever, trench feet, and trench mouth, were studied and controlled. Of the infectious diseases influenza (often complicated with pneumonia) was the most prevalent and the most fatal, there being 46,000 cases

treated, with 776 deaths. In the South African War the ratio of deaths was 65 from disease to 35 from wounds, while in the Great War the Canadian figures were 8.7 from disease to 91.3 from wounds.

This startling difference was largely due on the one hand to the greater destructive power of modern artillery, machine guns, bombs, etc., and the massing of enormous armies for long periods under the conditions of trench warfare, thus raising the proportion and severity of battle casualties. On the other hand, the prevention of disease and the excellent care of the sick and their rapid evacuation from the field enormously decreased loss from illness. Horrible as war is, it is well to remember that the experience gained in looking after masses of men under discipline and control has always resulted in an advancement in medical and surgical knowledge, which remains in the hands of the profession to be utilized for the preservation of life of the civil population.

The Nursing Sisters shared with the rest of the army the hardships and dangers of war, having:—

6 killed or died of wounds
6 wounded
15 drowned by enemy action
17 died of disease on service.

They also shared in the recognition of services well performed, receiving 328 decorations, 169 mention in dispatches, 76 brought to the notice of the Secretary for War.

That then is, in brief, a record of the Service in which all present served, and which could not have been accomplished without that help. It is a record to be proud of and will be preserved and handed down to your successors, who, imbued by the same spirit of devotion to duty, will always be ready to respond, should the need arise.

It is well at times to remind ourselves of these things, to renew old friendships, to remember those who went overseas, embued with the same spirit of sacrifice, but who did not come back to face the difficulties of a disorganized world, and also to remember those who have passed over since war work was completed.

As members of the local unit you will meet the trials and difficulties of this period of depression and unrest with the same stout hearts, the same cheerful faces, and the same kindly helping hands, with which you helped back to health and strength those to whom you ministered with such devotion during the war.

# HOSPITALS IN HOLLAND

*By* C. P. KNOTTENBELT, First Matron of the Municipal Hospitals, The Hague, Holland.

To foreigners, the name of Holland rouses visions of a population in wooden shoes, the men in galligaskins, the women wearing from six to twelve stout petticoats, the babies wrapped up in heavy garments, looking like miniature grown-ups, an old-world country, still revealing the queerness and quaintness of which Washington Irving has given us such a fascinating picture in his Rip van Winkle.

I remember quite well how, as a young woman of about 25, I went to a boarding-school in the north of Scotland to teach French and German. On arriving, I noticed some disappointment among my future pupils, and later on I was informed that the children had hoped to be taught by a mistress in wooden shoes, in the old Marken costume or something like it. I don't think the headmistress of the school would have relished her mistress dressed in that way.

No doubt, now that people so often go to foreign countries and show more interest in their neighbors, these ideas have changed. I trust our hospitals are already known to many of our colleagues from abroad. All the same, with a view to the International Congress of Nurses in Paris and Brussels, which for many will be followed by a trip to Holland, it may be worth while giving some idea of what is to be seen there.

In political and religious life, I believe Dutch people are more split up into small groups than any people I ever heard of. It seems contradictory, but it is a fact that, in spite of so many different factions, the Dutch are as a rule successful when it comes to achieving something, and with regard to hospitals, too.

Dutch hospitals may belong to the state, to the county, to the municipality, or may be semi-state-municipal; many are private hospitals, in that case mostly denominational, either Protestant or Roman Catholic; some are neutral. Their size, too, varies from big (1,300 patients) to quite small ones (10 patients).

The hospitals belonging to the state and municipality are mainly directed by a medical superintendent, together with a matron or lady-superintendent. Their nursing staff consists of graduate nurses and pupil nurses, the latter being usually in the minority. All large hospitals have a training school for nurses. Recently, many hospitals have started a preparatory school, while others are planning to open one. Nurses have a three-years' training, besides half a year for nursing maternity cases. Mental nurses also train three years. Since 1928 we have a state examination and registration. In the smaller hospitals and in children's hospitals, the nurses are but partly trained, and go for their final training to one of the larger hospitals.

Legally, nurses' working hours may not exceed 9 hours daily, no such regulations being in force for head nurses and sisters. In the municipal hospitals of Amsterdam, The Hague and Rotterdam, an 8-hour day is prescribed. In most hospitals, nurses wear the typical Dutch uniform (blue-linen dress, white apron, black shoes and stockings). State and municipal hospitals as a rule take in only a few private patients, or none at all. As it is impossible to give the names of all the hospitals of the cities you intend to visit, I shall mention the

bigger ones, although many of the small ones are of a very good standing.

In Amsterdam, the municipality has three hospitals, of which the Wilhelmina Gasthuis is the largest, accommodating about 1,300 patients. It was opened in 1893. I remember quite well that our Queen Wilhelmina, at that time a little girl of 12, came to Amsterdam for the ceremony of laying the foundation stone and a group of about 1,000 Amsterdam schoolchildren celebrated the event by singing the national anthem. I was one of those 1,000 children.

The Wilhelmina Gasthuis is built in pavilions. Since the building was completed, the hospital has been repeatedly and considerably enlarged. Although in the beginning it was not meant to be so, the Wilhelmina Gasthuis is gradually changing into university clinics. Any kind of illness and men, women and children are nursed there in wards containing from 30 to 6 patients. Besides the inpatients, the Wilhelmina Gasthuis has big out-patient departments.

While the Wilhelmina Gasthuis is the largest, the Binnengasthuis is the oldest of the municipal hospitals at Amsterdam. During our 80-years' war with Spain, the magistrate of Amsterdam, after denying the authority of the Spanish king, took possession of a convent built on the site of the present Binnengasthuis. From that date the indigent of Amsterdam were nursed there. In succeeding centuries many alterations and improvements were made.

Situated in one of the oldest parts of the city, the Binnengasthuis has retained its original picturesque aspect, which makes up in a way for the lack of gardens and trees, appreciated so much in our modern hospitals. Unlike the Wilhelmina Gasthuis, the Binnengasthuis has always been a university hospital, but as said before, the Wilhelmina Gasthuis nowadays draws large numbers of medical students. An interesting feature of the Binnengasthuis are the infants' cubicles, where, in order to prevent infection, all sick children are first nursed before being admitted to the children's ward. The third municipal hospital, the Tesselschade Ziekenhuis was only opened in 1920. Owing to the extension of the city and consequent lack of beds for the sick, one of the municipal orphanages was turned into a hospital, which, of course, entailed many alterations in the original building.

Amsterdam has many private hospitals. Among the denominational ones we find:

Protestant—Ned. Herv. Diaconessen Inrichting (Dutch Reformed Deaconess Institution), Luthersche Diaconessen Inrichting (Lutheran Deaconess Institution), Juliana Ziekenhuis (Juliana Hospital).

Roman Catholic — Onze-Lieve-Vrouwe Gasthuis (Holy Virgin Hospital).

Jewish—Nederlandsch Israelietisch Ziekenhuis (Dutch Jewish Hospital), Centraal Israelietisch Ziekenhuis (Central Jewish Hospital), Portugeesch Israelietisch Ziekenhuis (Portuguese Jewish Hospital).

Non-denominational — Burger Ziekenhuis (The Burgher's Hospital), Ziekenverpleging Prinsengracht (Hospital Prinsengracht), Boerhaave Kliniek (after the Dutch physician Boerhaave), Spinoza Kliniek (after the Dutch philosopher who lived in Amsterdam some 300 years ago). Besides, there are many hospitals confining themselves to special cases, for instance —The Children's Hospital, named after our Queen-Dowager, the Emma-Kinderziekenhuis; the cancer hospital which honors in its name "Anthony van Leeuwenhoek

Ziekenhuis", our great biologist born 300 years ago.

The Ned. Herv. Diaconessenhuis, which like most philanthropic institutions, started its work in a private house, and built a new hospital in 1912 on the Overtoom. The new hospital has wards for 36 patients and private rooms for 44 patients. The Luthersche Diaconessenhuis dates from 1894. Consequently it is less modern than the Ned. Herv. Diaconessenhuis. The Juliana Ziekenhuis, built in 1903, has some 130 beds.

The Roman Catholic Hospital "Onze - Lieve - Vrouwe Gasthuis" started with 50 patients and 14 nurses in 1880 in a private house on the Keizersgracht, the older part of Amsterdam. Soon it proved to be too small and already in 1898 the Roman Catholics erected a big hospital on the outskirts of the city which, after repeated extensions, has now a capacity of 750 beds. As Amsterdam has a densely-populated Jewish quarter, it stands to reason that the Jews were keen on having their own hospital. Of their three hospitals, the Ned. Isr. Ziekenhuis (300 beds) is the largest; the Centraal Isr. Ziekenhuis has 56 beds; the Portugeesch Isr. Ziekenhuis has about 50 beds. The non-denominational hospitals mainly accommodate private patients. They are all well equipped, without great luxury.

From Amsterdam it is only a quarter of an hour by train to Haarlem, the well-known bulb centre. It would make this article too long to give details of all the hospitals there, so after mentioning the Roman Catholic "Maria Stichting" and the Protestant "Deaconess Hospital", I would like to point out to you the St. Elisabeth's or Big Hospital, a semi-municipal-private institution. It can boast of being one of the oldest hospitals of Holland. The original hospital dates from 1354, but was replaced on its present spot in 1581 and named after Elisabeth of Thuringia. It has a most interesting history of which even nowadays, after the hospital has been beautifully modernized, we find many traces in the old Delft-ware and Dutch pewter in the nurses' dining room and the room for the hospital committee. Having been matron there myself for seven years, I quite see the advantage of the atmosphere of an old home with beautiful old architecture and fine old china combined with all those modern conveniences that are indispensable in an up-to-date institution.

During my own matronship in the hospital, I sometimes could not help feeling slightly hurt when many people seemed to be more interested in the antiques than in the way the patients were nursed. Lately, the hospital has been greatly rebuilt and extended. Fortunately, the old style has been kept intact. Thus, the hospital has remained a worthy neighbor of the interesting Frans Hals Museum, just opposite.

In the neighborhood of Haarlem, at Santpoort, we find one of our big lunatic asylums, situated in a lovely spot in the dunes. Its former name, "Meer en Berg" (Lake and Mountain), suggests a landscape more or less Swiss. Nothing of the kind, though. The people of the lowlands, although being somewhat matter of fact by nature, are not devoid of imagination and it is only a short step for them to see mountains in dunes and lakes in small ponds. So if you look for Switzerland you will be disappointed, but if you care for a pretty spot in our beautiful dunes you will rejoice with us that about 1,300 of our mental patients are nursed there.

After leaving Haarlem, the train takes us south in 20 minutes to Leiden, and I am sure you will not regret the time spent going over the "Academische Ziekenhuizen"

(State University Hospital). The clinics are quite modern, having been completed only this year. Once more we meet the pavilion system; every pavilion is surrounded by gardens, which in summer time abound in flowers. On entering the different pavilions, one is struck with the ample scale on which they are built. The corridors and wards are spacious, the painting in various bright colors helps to give the feeling of a cheerful welcome to all who enter, either to help to relieve pain or to be relieved.

After Leiden, we continue our way, either by tramcar (one hour) or by railway (10 minutes) to The Hague.

There the Gemeente Ziekenhuizen (Municipal Hospitals) first claim our attention. The municipality has four hospitals of its own where its patients can be nursed. These are: I, The Gemeente Ziekenhuis, Zuidwal; II, The Gemeente Ziekenhuis, Slijkeinde; III, The Gemeente Ziekenhuis, Tapijtweg; IV, The Temporary Buildings, Zusterstraat.

In the first hospital all kinds of patients are nursed with the exception of scarlet fever, whooping cough, erysipelas—in fact, most notifiable infectious diseases. These are taken in the Temporary Buildings (Zusterstraat, IV).

For obstetric and gynaecological cases, the hospital Tapijtweg (III) is set apart. In the hospital Slijkeinde (II) only medical cases are nursed. The hospital Zuidwal (I) is the biggest and most modern. It was founded in 1823, and since then has been constantly enlarged and improved upon. In 1925 the new operating department was opened and in 1931 the preparatory school for nurses, which originally was started in one class room, was moved to new premises next to the nurses' dining room. Here the probationers have their class room, their model bathroom, their study, their model kitchen. On the floors above we find the new nurses' home.

The municipality has no room for all its patients in its own hospitals. A number of beds in private hospitals are at its disposal for patients who express a desire to be nursed there either from religious motives or because their relations prefer to have them nearer, expenses being defrayed in so far as necessary by the town. Quite close to the Municipal Hospital, Zuidwal, is the Roman Catholic Hospital "Westeinde", also in the old part of the city. After repeated alterations it now stands there, able to cope with the manifold duties it has to fulfil. In spite of several enlargements, it has managed to retain a large space for its beautiful gardens.

The Diaconessenhuis "Bronovo" (Deaconess House), first situated in the heart of the city, wanted modernizing and achieved this in an ideal spot at the extreme edge of the town. The new building, opened in 1932 by Princess Juliana, is meant to accommodate 160 patients, while 125 deaconesses (many of whom are engaged in district nursing) have their rooms in the nurses' home.

On entering the building, the visitor is struck by its severe beauty and yet cheerful aspect. The whole building is surrounded by spacious gardens, which promise shady corners and pretty walks when they have outgrown their baby stage. Also on the outskirts of The Hague, but in an opposite direction, the Red Cross had a beautiful building site at its disposal, and in 1925 opened a new hospital for 150 patients, half of which are nursed in private rooms. The staff numbers 82 nurses, besides the nurses on special duty.

And now we say good-bye to The Hague, and our next visit will be to the Rotterdam hospitals. I am afraid that mentioning so many hospitals has taxed your attention too much. Yet we must not leave Holland without paying a visit to Rotterdam. Its extensive carrying trade necessitates the world famous docks and harbors, and the Hospital Coolsingel is always in readiness to receive the inevitable casualties occurring there. The hospital is old, but well equipped for 800 patients. The Municipal Hospital on the Bergweg was built when the growing city wanted more hospital accommodation. In this hospital is room for 400 patients. The hospital for tropical disease was opened a few years ago and is of much value in a city where boats from the Orient regularly arrive.

I hope in this brief survey to have succeeded in giving you some impression of the care of the sick in our Dutch towns. Needless to say, I could point out only a very few out of our large number of excellent hospitals. I trust these lines may make you desirous of becoming personally acquainted with the institutions mentioned.

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## A PROUD MOMENT

Years ago, a young nurse, inexperienced in organisation work, with much timidity presented the first annual report of the Saskatchewan Registered Nurses Association to a general meeting of the Canadian Nurses Association. Much that occurred at that meeting has been forgotten, but memory treasures still the gracious, encouraging words spoken by Miss Mary Agnes Snively when, at the close of the meeting, she sought the western representative and expressed the pleasure it had been to her to hear of nursing development in one of the more recently organised provinces.

Since that day in 1918 there have been other occasions when the same kindly encouragement has been spoken or written by Miss Snively. A letter in her familiar and characteristic writing is opened first of all whenever one appears among the mail at the National Office. Early in January, another such letter was received by the Executive Secretary and retiring Editor, conveying Miss Snively's kindly commendation and enclosing a generous cheque for the *Journal*. Such evidence of continued interest and support from the Founder of the Canadian Nurses Association should stimulate all members to follow her excellent example.

Miss Snively is Honorary President and a Life Member of the Canadian Nurses Association. The nurses of Canada will look forward in joining with her in celebrating the 25th anniversary of the Association in Toronto in 1934.

# THREE NOTABLE NURSING CAREERS

Recognition of years of service was fittingly, made during recent weeks, to Miss Jane Craig, Miss Lillian Phillips, and Miss Jennie Webster, of Montreal, all three having made a distinctive and valuable contribution to nursing which has extended far beyond the City and even the Province.

Miss Jane Craig completed twenty-five years as lady superintendent of the Montreal Western Hospital before she resigned toward the end of 1932. A daughter of Montreal, Miss Craig graduated as a nurse in 1905 from St. Luke's Hospital, Chicago, and in 1907 was appointed to the position that she filled most capably for a quarter of a century. Alert always to the requirements of nursing education, Miss Craig was responsible for improved standards in nursing care and teaching methods and also for the efficient administration of the Hospital throughout her association with that institution.

Miss Lillian Phillips, Superintentendent of the Montreal Foundling Hospital for the past thirty years, built up an institution which grew from the smallest of beginnings to one which will be of lasting benefit to the entire community. Into the history of nursing organisation in Montreal and in the Province of Quebec is woven the loyal and stimulating support of Miss Phillips. She was appointed secretary of the Montreal Graduate Nurses' Association at its organisation in 1905, an office most competently filled until her election as President in 1909. Probably Miss Phillips' length of presidency is unique in Canada, as she was presiding officer until 1927. During that time many changes took place. A Club House for the Association was rented in 1916 and a resident secretary-treasurer appointed. This served the purpose until the residence on Bishop Street was purchased in 1925. In the interval the office of resident registrar had been established. When the Association of Registered Nurses of the Province of Quebec was organised in 1920, Miss Phillips became Recording Secretary and Treasurer, and served the organisation in those offices for eight years.

*MISS JANE CRAIG*

*Courtesy, The Montreal Star*

Reference to Miss Jennie Webster, Night Superintendent of the Montreal General Hospital, immediately brings to mind a career that in length of service must constitute a record in the nursing world. An early graduate of the Hospital, Miss Webster was appointed Night Superintendent in May, 1900, and since then, without interruption, she has continued in that position.

Following graduation, Miss Webster had some experience in private nursing and hospital admin-

*MISS LILLIAN PHILLIPS*

istration before she accepted the appointment which she held so efficiently for more than three decades. Announcement of Miss Webster's resignation, late in December, was received with deep regret, not only by the medical and nursing professions, but by all classes of citizens in Montreal. Further reference to Miss Webster's unique career will be published in a later issue of the *Journal*.

These three nurses have contributed in large measure to nursing development and service to the community, each according to the exigencies of her position. It is gratifying to all their associates that Miss Craig and Miss Phillips will continue to reside in Montreal. Miss Webster goes to Winnipeg, where she will preside over the home of two orphan nephews.

In honour of each one, there were numerous presentations and social gatherings, including a farewell reception on January 8th for Miss Webster at the Nurses' Residence, when over five hundred nurses, doctors and other friends called to bid her adieu. Miss Phillips and Miss Craig were among those present.

The *Journal* joins in offering congratulations to these nurses on their years of service and hopes that, in the future, they may find full enjoyment in the fruition of plans that have been made during their busy lives for this time when duty will be less demanding.

*MISS JENNIE WEBSTER*

*Courtesy, Alumnae Association*
*The Montreal General Hospital*

# SCHIZOPHRENIA

*By* A. ELIZABETH PORTER, Graduate, Ontario Hospital, Whitby, Ontario.

The study of the Schizophrenic type of mental illness presents a wide field to the student of Psychiatry. The sufferers from this malady form the majority of the permanent inmates of all mental hospitals. The disease is little understood as to its causes and treatment, and although great advances have been made along these lines, there is still much to be learned.

The word Schizophrenia is taken from two Greek words meaning "the splitting of the mind or personality." This word is considered to more clearly describe the condition than the older term Dementia Praecox, and is now more commonly used.

Schizophrenia, in its typical form, is a slow, steady deterioration of the personality. It expresses itself in disorders of feeling, of conduct and of thought and in an increasing withdrawal of interest in the environment. It is a disorder of youth, frequently met with in adolescence. Two-thirds of the cases occur between the ages of 15 and 30 years. The greatest number of cases occur in about the 25th year, with a gradual decrease in the number after that year, and very rarely are cases met with after the 40th year.

The causes of this condition are rather obscure. Heredity is a debatable point — some psychiatrists think that it has much to do with mental illness, while others think that it does not influence the onset of the disease. However, we do know that in many cases of the disease, family history shows some form of mental illness.

Poor childhood training, unhappy family life, alcoholism in the parents, and too much or too little affection, all seem to predispose toward attacks of Schizophrenia. The child who is a little different, a little too clever, or dull, who is seclusive and does not mingle with others, and the daydreamer, is often a candidate for the ranks of this illness. The nearest to the true cause might be stated thus: the progressive inability of the individual to adapt himself to his environment.

An attack is sometimes brought on by a serious physical illness, particularly a dangerous infection. A death in the family, the sudden loss of money, or worry over business affairs may bring on an attack. An unhappy love affair may be the exciting cause. Whatever cause may be seen, either exciting or predisposing, to cause the development of this psychosis, it may be said that, having found this world and the business of living too great a burden, for his peculiar mental constitution, this individual has built himself a world of his own. This new world of his is a dream world, filled with phantasies and known only to himself.

Under the general head of Schizophrenia have been grouped four sub-divisions. These four types have all the same basis, namely, that of a functional brain disorder, there being no change in the brain itself. These types are fairly distinctive, and yet are not very clear-cut as there are some symptoms common to all, and again no two individual cases are absolutely similar. These four types are—the Simplex, Catatonic, Hebephrenic and Paranoid forms.

The symptoms vary so much with each individual case that it is impossible to set down definite

rules, but there are certain symptoms that are common to the whole group. One of these is the failure of affect, or emotional blunting. This shows itself in apathy and indifference. The patient does not seem to appreciate joy, or sorrow, or fear, but is quite indifferent to his condition and to his surroundings. There is also a certain dreaminess and lack of reality. The patient lives in a world of his own beyond the reach of friends and doctors. There is marked disharmony between mood and thought. Often these patients express ideas without any emotion which, in the normal person, would cause feelings of remorse, or pity, or joy, and so on. Situations of great emotional value are met with complete indifference. Often there is meaningless laughter and a stereotyped, silly smiling attitude, which is not real mirth or gaiety. The patient loses all interest in his personal appearance and requires constant attention and supervision.

Ideas of reference are common. The patient suffers from the idea that people are talking about him, are plotting against him, and that every happening has some reference to himself. These ideas are the foundation of the persecutory delusions and also of many others. He may think that people are reading his thoughts or that he is being influenced by wireless or by electricity. Delusions of a grandiose nature also appear. The patient is usually very sensitive and suspicious, and feels that the whole world is centred about him and that he is marked out either for persecution or for some great honour.

Hallucinations of hearing are very common. They frequently come to have great influence over the patient's actions. The patient hears a voice, which is really the working of his own schizoid mind, telling him to do a certain thing and though he may know it is wrong, yet he is compelled to do it. On being asked why he did such a thing, the reply is, that a voice told him to do it. He may say it is the voice of God, or of some friend or relative. Destructive and violent actions often result from these hallucinations. Visual hallucinations and those of taste and smell are also frequent. Thus the patient may say that he sees bright lights in the ceiling or angels in the sky. He may say that the food is poisoned or that the air is filled with strange odours. There are many more of these ideas but these examples are merely given here for illustrative purposes.

*Schizophrenia Simplex*

To deal with the sub-divisions of Schizophrenia now, we will take the Simplex type. This form is chiefly characterized by a loss of ambition. These are the wanderers — the professional hoboes — the people who are continually changing from one job to another, moving about the country from place to place, never satisfied and yet never able to improve their station in life. Always they are going to make a great success of their next undertaking but their interest and ambition always fades away and they weary of the effort of really doing anything worth while. They dream great things but never have the ambition and perseverance to achieve their ends.

They have no mental change and are merely sunk in apathy and emotional dullness. Life has been too hard for them, but instead of developing a psychosis they just let things pass them by and do not bother. They are content with little. They often do good work at a routine job in a subordinate capacity. They make no effort to plan for the future, or to acquire more than will keep them from day to

day. Frequently, in later life, they become public charges although rarely reaching the mental hospital.

*Catatonia*

The catatonic type is more readily differentiated than any of the other types of Schizophrenia. It has symptoms and a course peculiar to itself. There are two chief phases of Catatonia—the stage of catatonic stupor and the excited state. Between these states there is a depressed stage when the patient appears in a more or less normal state. The onset of the illness is rapid with little or no premonitory symptoms. Previous to the attack there has been gradual loss of interest, apathy, a lack of concentration, a dreaminess and often unusual behaviour. Gradually a state of stupor develops. The patient is mute, ignores or refuses food, and all activities are so lessened that he remains idly sitting or standing in one position. There is a vacant facial expression and no apparent interest is taken in his surroundings. While in this state the patient has to be dressed and undressed and moved about in bed. He takes no interest in his personal habits. Mannerisms are common. It may be necessary to tube feed these patients for months at a time.

Often, while in a catatonic stupor, the patient lies rigidly or curled up in bed. While in this cataleptic state, they will allow their bodies and limbs to be placed in various positions and make no effort to move them again. For example, if a hand is raised, it will remain in that position until the attendant moves it again. This is known as flexibilitas cerea, when the body can be moulded into any shape.

While in the stupor, the patient does not appear to know what is going on about him, yet he does understand and, when in the excited state or in the in-between periods, may give a detailed account of events that have taken place.

Without any warning, the patient may suddenly become active, talk, and ask and answer questions. A state of extreme excitement now comes over the patient, he is impulsive, suddenly striking people and things about him. He is noisy, singing and shouting and generally very active and very restless. This excited state may last for hours, days, or even weeks at a time. During the excited stage, there are often both homicidal and suicidal tendencies.

Acts of violence are usually associated with hallucinations. Often too, the patient expresses delusions. They feel that they are commanded to do certain things, that they are all-powerful or that they are being persecuted. They often cannot eat for the fear that there is poison in the food, that they can taste or smell it. This is due to the hallucinations of taste and smell.

Deterioration is fairly rapid. As time goes on, these patients become more careless of their personal habits and appearance, destructive to their clothing, showing no interest in their own comfort whatsoever. They live for years, alternating between phases of excitement and stupor. In hospitals some may do some light work as occupational therapy, or gardening, and other things, but many refuse to do anything. Some recover from a first attack and some recover from even later attacks but many never recover. The prognosis in catatonia is still poor, even today.

*Hebephrenia*

Hebephrenic Schizophrenia appears to occur more often in younger people than do the Catatonic and paranoid forms. There

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are often symptoms of these other forms present, which make it hard to diagnose Hebephrenia in some cases. However, it is marked by periods of wild excitement alternating with periods of depression and tearfulness. There are frequently fantastic illusions and hallucinations.

The previous history of the hebephrenic type shows an unstable emotional condition. There may be a history of tantrums, of a too pious, too conscientious type, apt to be too idealistic and prone to brood over trivial matters. They have generally been looked upon as queer or odd. They laugh or weep without very good cause, or have violent outbursts of anger, explosive in nature, and soon passing away.

Hallucinations of sight and of hearing are very common in Hebephrenia, especially those of a symbolic interpretation. These come and go in the course of the disorder. The vivid hallucinations especially dominate the picture. Their delusions are very changeable and fantastic: they may say that they have no brains any more, or that their back is broken.

The hebephrenic patient suffers much from ideas of reference. He feels that he is being watched and made fun of. Sometimes there are feelings of being under the influence of some unknown power.

Deterioration is rapid. It soon reaches a condition of silly, impulsive activity with poor emotional reactions, great incoherence of speech and thought, with many varied hallucinations and absurd ideas. Like the catatonics, they take little interest in their personal habits, appearance and comfort and so require constant attention. The prognosis is poor in Hebephrenia.

*Paranoid Schizophrenia*

This type of Schizophrenia usually develops between the ages of thirty and thirty-five years. The delusions expressed are many, unsystematized and changeable. They are usually of a very fantastic and illogical nature. Hallucinations accompany these delusions.

The idea may be of any type. Sometimes there are ideas of persecution—someone is attempting to poison the patient, to harm, or to destroy him, or is trying to take away his property or money and so forth. In fact, these ideas of persecution often cause much trouble before the patient can be placed in the hospital under proper supervision. Again he may have depressive ideas, or probably ideas of great wealth and power known as grandiose delusions.

Deterioration is not so great in the paranoid type. The personality is better preserved and they have rather more interest in themselves than the other types do. In advanced cases there are seen to be mannerisms, incoherence in train of thought, and lack of interest. The prognosis here is not good either.

Many theories have been advanced as to the cause, diagnosis and treatment of Schizophrenia and much progress has been made along these lines. In the treatment, of which nothing has been said in this article, the main hope rests on the prevention of the onset of the illness, through treatment of persons presenting unusual behaviour, by the mental health clinics, and by improved childhood training. There is still much to be discovered regarding this disorder from all angles. As time goes on, and through research, psychiatrists gain more knowledge of this disorder, it is hoped that a more favorable prognosis may be given.

# THE EDITOR'S DESK

The new Editor of The Canadian Nurse is now engaged in taking over her duties and responsibilities. She reported for duty something less than a week ago, and her present state of mental confusion reminds her of those early days in training when, being sent on an errand to the drug room, she found herself in the laundry, with no clear idea either of how she got there or of how she was to get back to the ward again.

Let it be said, however, that her path is being smoothed, at every turn, by the unfailing patience and courtesy of the Executive Secretary and former Editor of the Journal, Miss Jean S. Wilson, who has left nothing undone which would help to make the transfer easy and pleasant. In an early issue of the Journal, it is hoped that all previous editors may be prevailed upon to tell something of the contribution each has made toward its growth and development, and, at that time, more extended reference will be made to Miss Wilson's accomplishment.

Anyone familiar with the heavy responsibility and endless detail involved in the secretaryship of a national organization, or in the direction of a professional journal, would naturally suppose that either task might well absorb the total energies of one person. Miss Wilson has carried the double burden with characteristic modesty and quiet efficiency for more than eight years. In spite of the fact that the Executive Secretary has, during the past three months, closed one national office and opened another in a distant city, the direction of the Journal has been so orderly and systematic that the new editor ought to be able to carry on without loss of time or duplication of effort.

Miss Wilson, in her farewell editorial, ventured to hope that the members of the Canadian Nurses Association will consider that she has "held the line". As one of the members of that Association who perhaps has had unusual opportunities for judging, the new Editor suggests that the line has indeed been held with courage and devotion in the past, and that it should continue to be so held in the future; therefore, with the consent of the President of the Canadian Nurses Association, Miss Wilson has been requested to take charge of a department in the Journal which will report upon the various projects and activities associated with the work of the Executive Secretary at the National Office, and will keep Canadian nurses informed concerning developments in the various provincial nursing associations. When she is relieved of the responsibilities of the editorship, it will be possible for the Executive Secretary to give her entire time and energy to those problems which the recurrent demands of the Journal have inevitably pushed into the background.

Meanwhile, the new Editor must seek to comprehend the complexities of the task she has undertaken. She has no illusions about its difficulties; they are plainly in evidence. In times like these, there are strong elements of risk in any new venture—yet she has faith to believe that there is a reasonable hope of success. Foresight and caution have been exercised in planning the re-organization of the Journal on its present basis. The President of the Canadian Nurses Association and her associates have pondered the wisdom of every move before it was made. The successive steps may clearly be traced by studying the President's mess-

ages to the members. Nothing has been left to chance and a wise guiding policy has been formulated and closely followed to its logical conclusion.

There will be no departure from this policy of caution and commonsense. It is obviously too early to discuss, in print, any contemplated changes. These cannot be decided upon until they have been submitted to the proper authorities for official scrutiny and sanction. The immediate task is to take full advantage of all the work that has already been accomplished, to continue to exercise the fullest measure of economy which efficient administration permits, and gradually to introduce such new features as close study and careful analysis indicate as likely to strengthen the Journal and add to its interest and usefulness.

If encouragement were needed, it surely has been generously supplied by the good wishes which have already reached the Editor's desk. The first letter opened was from the President of the Canadian Nurses Association. It conveyed her greetings — and enclosed a check for an annual subscription— an excellent presidential precedent which is worthy of emulation by all members. The first visiting card was that of Dr. Helen MacMurchy, Chief, Child Welfare Division of the Department of Pensions and National Health, and former Editor of the Journal, of whom more will be said in a later issue. Many cordial messages have been received from officers of provincial associations, from nursing colleagues in many lands and from former students. Much wise counsel has been given by nursing leaders and teachers and the President and the Executive Secretary of the American Hospital Association have expressed a kindly interest.

The nursing press, as represented by The International Nursing Review, The British Journal of Nursing, The American Journal of Nursing, The Public Health Nurse, The Trained Nurse and Hospital Review, and the official organ of nursing in Hungary, have all commented favourably on the new venture and have wished it success. At this point the Editor would like to make public acknowledgment of the debt which she owes to the editorial and business staffs of The American Journal of Nursing and of The Public Health Nurse. Generous opportunities were afforded her of studying at close range, the editorial and administrative organization of these outstanding publications. Such evidences of international goodwill are heartening and are an earnest of future cordial relationships.

Inevitably, in this first editorial, there must be something of a direct and personal approach which is not usually appropriate or permitted. The Editor asks permission to depart, on this unique occasion, from the impersonality to which, in the future, she must strictly adhere. The nurses of the Province of Quebec and of the City of Montreal have made this incurable Westerner feel that she is welcome. The streets of this ancient and picturesque city and the sound of the French tongue recall experiences in other lands and add richness and colour to the familiar Canadian scene. It is good to be home again.

The Editor thanks the nurses of Canada for the trust they have reposed in her. It is in a spirit of real humility that she sits at her desk and takes her pen in hand. She applies to herself that admonition once given to the greatest of nursing saints: "Seek to do well, for there be those that have faith in thee."

# POST-NATAL CARE

*By* Dr. W. A. DAFOE, Toronto, Ontario.

Any organisation which has as its object the welfare of our mothers and babies deserves all our possible support, and I look upon my association with the Mothercraft Movement as a particular privilege.

Prophylactic measures for post-natal care commence during the early pre-natal period and are continued throughout pregnancy. This includes a careful physical survey of the patient with the notation of any organic weakness. Pregnancy makes great demands on every system of the body, and the expectant mother must meet these demands by carrying out a schedule of careful training in regard to rest, sleep, proper diet, exercises, clothes and physical care. A normal patient should be able to carry out her accustomed daily routine with the addition of increased rest and sleep. This fact was clearly demonstrated to me in the case of a patient I saw in the early months of expectant motherhood, who was, at the same time, carrying on with her profession of a circus bare back rider. With the pursuit of scientific data, and the accompaniment of a small boy, as excuses, I went to see the circus and watched this lady do back-flips, front-somersaults and cartwheels on and off the horse and over the circus ring without apparent trouble, and this had been a bi-daily procedure for several months.

There are many worries and fears during pregnancy which should be met by a sympathetic attitude; they should be brought forward for discussion, rather than hidden away. So many of these troubles are found to be needless. The unborn baby is a parasite living off its parent and it will usually flourish in spite of abnormal conditions of the mother. It is not influenced by maternal impressions and its physical and mental possibilities have their origin in the sex-cells of the parents long before it takes bodily form. This fact does not appear to be clearly understood.

Due to the increased pre-natal care, the serious complication of convulsions is becoming a rarity. A great deal of valuable work along this line has been carried out in the University of Toronto. Modern medicine has given us many accurate ways of diagnosing early symptoms of trouble, and the mother-to-be should be informed of the warning signs that require immediate notification. In this way, serious conditions will be avoided.

The first three months of a new mother's life is a critical period for herself and the baby. It is a time of many new adjustments. She has the cares and responsibilities of a new baby and, in most cases, the care of the home as well. Emotional disturbances may appear and even mental upsets occur, but their duration is short and the mother needs encouragement. This is a time when practical help, in many ways, from the new father is most essential.

During the lying-in period, the mother is recovering from the effects of pregnancy and labour. This is the period she has been looking forward to for nine months and she needs a great part of this time to commune with her new baby and visitations should be in-

(A paper read before a meeting of the Canadian Mothercraft Society, Toronto.)

frequent. We always take it for granted that the mother will nurse her baby. Not only is this the best for the baby, but it helps considerably in bringing back the reproductive organs to their size, strength and consistency.

Amongst the immediate complications of child birth, infection of the reproductive tract occurs most frequently. Due to the mechanism of labour, there are always wounded places and organisms which normally live in the lower portion of the tract can reach these areas with greater ease at this period, than at any other time. Fortunately these organisms are not of the dangerous type and nature in her own wonderful way, immediately throws forward strong defensive powers and neutralizes their effect.

There is, however, one family of bacteria which, on account of its virulent growth, often breaks through the defensive barrier, grows wild in the blood stream and settles in various organs of the body. It belongs to the same family as the cause of many serious conditions such as scarlet fever, erysipelas, septic sore throats and others. It is readily transferable and thus is found more frequently in the cities than in the country. Admission is gained from without, but in a few cases it may be carried from infected areas in other parts of the body. This infection is more prevalent during the winter months when people are restricted more to indoor life. Special care must be exerted to prevent colds and sore throats at this time. It is interesting to know that patients with a history of scarlet fever are less susceptible to this infection than others. Possibly in the near future, protection may be given by means of the new scarlet fever toxoid.

Long before the knowledge of organisms, Semmelweis of Vienna cut the mortality rate of the cases under his supervision 75% by the simple measures of insisting that his students wash their hands carefully and soak them in chlorine water. Pasteur, about 25 years later, described the appearance of these organisms as little circles in chains, an excellent description which is still used. Bacteriology has advanced a long way since then, but we still have far to go yet in stamping out this serious complication. The seriousness of this problem is clearly realised in our teaching centres and investigations are proceeding continuously to combat it. In the meantime, we are attempting to lower its incidence by our teaching to students and nurses of pre-natal care, as well as the teaching and practical application of meticulous technique in the care of the mother at childbirth and the immediate post-natal period.

We must realise that our responsibility and service to mothers does not end when they are able to be up and around. Mothers must be taught the necessity of post-natal examinations and they should expect and insist upon these being carried out. As mentioned before, pregnancy places extra work on every system of the body and labour always produces some traumatic disturbances to the reproductive system. During the post-natal examination, summation of the effects of pregnancy and labour may be made and measures of treatment should be instituted and continued until the abnormal conditions are cured. Following this, mothers should be seen at least once a year until after the menopause. This care is vitally important to the future health of the mother and I believe it to be one of the most important prophylactic measures in the prevention of malignant conditions in that part of the body.

# LETTING OUR CHILDREN GROW UP

*By* Mrs. W. T. B. MITCHELL, B.A., R.N.

Director of Parent Education, The Mental Hygiene Institute; Chairman, Section of Education, Canadian Council on Child and Family Welfare.

About the hardest thing parents have to learn is that their children do not belong to them. They belong to themselves and to the future. The parent's role is to provide guidance and education of the young so that they may become independent and contributing members of a social group. To work planfully, happily and unconditionally toward that goal, requires real unselfish love for the child and an appreciation and respect for his individuality. To have helped in the development of a mature, grown-up personality brings with it the highest reward of parenthood.

The first and most important duty of the parents and family is to provide security and affection in the home relationships. Children all need affection—particularly the kind of affection that can be counted upon—that ensures understanding, patience and consideration under the most difficult circumstances. It is nothing short of cruel to tell a child "If you behave that way mother and daddy cannot love you," or "You are so naughty I am going away to stay," or "If you don't behave we'll put you into an institution." Any child who is subjected to such frequent threats to this security has the very foundation of healthy personality growth undermined. Every child needs to feel *sure* of the affection of his parents for each other and equally for him and his brothers and sisters. It is a seriously disintegrating thing when a child is torn between loyalty and affection for one parent and loyalty and affection for the other. Yet such a situation inevitably arises when parents are incompatible and get at each other through the child, or unconsciously use him as the outlet for their unsatisfied emotional lives.

John, aged 8 years, is an only child. His parents were married after a few days' courtship. Except for a few weeks following the marriage, they have quarrelled constantly. John was an unwanted baby, but since his birth the mother has devoted herself to him, doing everything for him—overprotecting him, and shutting him away from the normal outside contacts. The parents disagree openly as to matters of discipline. The mother criticises the father for his severity with the boy and his lack of affection and consideration for her, and commiserates the boy in a very evident attempt at turning him against the father. The boy admires the father "because he is big and can do things," yet is very dependent upon the mother. He is in a constant state of conflict and insecurity, which is giving rise, at the present time, to such symptoms as restless sleep, stammering, food capriciousness and temper tantrums. Under such circumstances of strain and unstability, this child cannot grow up in an emotionally healthy way.

Another frequent source of feelings of insecurity comes about when parents show partiality in their treatment of their children. Praising one child, nagging another, making comparisons between them, holding up one child

continually as a model to others—continual fault-finding—expressed disappointment—all of this treatment must surely contribute to a lack of confidence in the self and feelings of inadequacy, to jealousies which develop when an individual feels insecure in his affectional life, to weakening of initiative and courage to do one's best.

Children must be appreciated for what they themselves are—evaluated in terms of what they themselves are able to do. Every individual has a contribution to make—a self to express. His growing-up should not be warped or prevented by inferiority feelings and insecurities, arising out of family partialities or personal competitive comparisons.

So far we have been stressing the need of every child for parental affection. Children cannot thrive without love, but they can have too much of it. Or we might better say—they can have too much of the wrong kind of love—the kind popularly termed "Smother Love." Let us see what we mean by the "wrong" kind of love.

Many parents find it difficult to let their children grow up. There is a great deal of pleasure and satisfaction to be derived through the dependence of the young. The attachment of parent to child is a reciprocal dependence. It is full of opportunities for mutual satisfactions. It comes about naturally during the helpless period of infancy, is easy to continue and difficult to break away from. Only a full understanding of the risks involved and a determination to see that the child has a reasonable chance to wean himself away from the home and family dependencies, will prevent the child from being crippled by them — from being "smothered" by parental love and affection.

The little child is very helpless and dependent at birth. He must be fed, bathed, clothed, put to sleep. Such ministrations are a source of great emotional satisfaction to the parent. She feels adequate and essential. The infant, too, finds the parent a source of comfort and satisfaction—an answer to needs. What begins as a perfectly normal responsive relationship, may all too easily develop beyond that. The mother who will not give her baby a bottle, because she cannot forego the pleasure of his absolute dependence upon her; the mother who prides herself upon taking her 7-year-old child to school every day, when she should be encouraging him to go by himself; the unhappily married or widowed mother who lavishes intense affection upon the child, when the normal outlet for such affection is denied her; these mothers are storing up very real difficulties for themselves and for their children. They are using the dependencies of their children to bolster up their own emotional insecurities. They are doing all in their power to bind their children to them by the cords of emotional dependencies. This is not letting children grow up.

Mary is a gentle, submissive girl of 19 years, the eldest of a family of three. For several years she was an only child—the only one the parents expected to have. She was very precious to her middle-aged mother. From the beginning the relationship between mother and daughter was very close. Mary's mother did everything for her—could not bear to have the child out of sight—consequently, Mary had a tutor and did not go to school. The mother was most demonstrative, and was always present to protect Mary from any disagreeable consequences of her own behaviour. Mary was the centre of attention for the whole family as well. Anything she did was

right. The unexpected birth of two brothers scarcely interrupted the intent relationship between mother and daughter. When Mary was nineteen, it was decided that she must go to finishing school. Mary dreaded leaving her mother and home. She was accompanied to school by her mother, who was most solicitous about arrangements for Mary's comfort. Mary wept bitterly when her mother left. She found it difficult to enter into the competitive school situation. She was bewildered by even the moderate criticism, the casualness of the contacts, and her own inability to fit into the groups. She was constantly looking for help and reassurance. She became depressed and had no appetite. She spent hours writing homesick letters to her mother. Finally, she developed a very disturbing cough. Repeated physical examinations revealed no cause for this distressing symptom, but it persisted. Finally, the cough became so distressing, her sleep so broken, that it was decided that Mary must go home for a rest.

Mary is quite well at home. She is mother's faithful shadow. She has no friends of her own age. Any mention of a return to school is enough to bring a few days' distressing coughing. Mary's mother says, complacently,—"I don't believe we will be able to let Mary go back to school—but she is such a lovable person to have around." This is "smother love." But even Mary's mother is observing wistfully the engagements, the marriages among the young people who should normally be Mary's friends. Even she is beginning to wonder why Mary has no "young man."

Again, let us take the case of Will. He is the oldest child of a family of five. His father died when he was fifteen and left the family in difficult circumstances. Will left school and went to work. He was a steady, willing worker. He brought every penny he earned home to his mother. He helped her around the house. There was not time for the normal recreational activities of a boy his age, and no money to spend on them. Will and his mother became very dependent upon each other. She talked over her worries and problems with Will, just as she had formerly done with her husband. Will comforted and sustained her. He became known and much approved of as a model son—so affectionate, so sympathetic, so sacrificing—what would Mrs. A. do without him to lean upon? Apparently no one thought what might be happening to Will.

When Will was 20 years old he met a girl and fell in love with her. His mother objected strenuously—the girl was not good enough for him—Will was too young to marry yet. How could he support two families?

The resulting long drawn out conflict between Will's natural adult desire to choose a mate and to establish himself as the head of a family, and the pull of the more infantile, immature emotional attachment to his mother and feelings of loyalty to her, has almost destroyed Will. He has periods of serious depression — such deep feelings of frustration as to make life seem not worth living. Will has not been allowed to grow up. He too is a victim of "smother love."

I should not like to leave you with the impression that smothering affection is limited to mothers. The father-daughter relationship may be equally emotionally handicapping. Fathers, too, find it difficult to give up their daughters —to let them grow up emotionally. Again, by the father domineering,

by his indifference, by his harsh discipline he may drive the emotionally developing child back upon the very dependencies the child is struggling away from. For the normal progression of his emotional life, the young boy needs help in freeing himself from the maternal dependencies. This can best and most naturally be supplied through the contacts and comradeship with the father. There is no substitute for such an intelligent comradeship. Any father who is too busy, too ambitious, too indifferent, who deprives his son of this help, is making it difficult for him to grow up. In conclusion—to mothers and fathers who are perhaps unconsciously clutching at their children — trying to live through them—disturbed at their natural efforts to get away — to parents who are preventing their children "growing up," I would say —*Free them!* unless you can renounce your hold voluntarily, even gladly, you run the definite risk of having nothing.

To those parents who are not themselves grown up enough to find happiness in deliberately helping their children establish their independence, to those who must have something dependent on them, I would make a suggestion. I would perhaps suggest that they might find some help if they read and ponder over the scene from "The Pretenders", when Ibsen makes King Skule ask the prophetic seer Jatgeir, the Scald, to be a son to him and cries out "I must have someone by me who sinks his own will entirely in mine, who believes in me unflinchingly, who will cling alone to me in good hap and ill, who lives only to shed light and warmth over my life, and must die if I fall." Jatgier answers briefly—"Buy yourself a dog, my Lord."

## CHARACTER MORE IMPORTANT THAN GRADES

Uncertain character and shocking manners are found in graduates of colleges and often of professional schools, said Nicholas Murray Butler, president of Columbia University, in his annual report made public in late December. Dr. Butler feels that the mere passing of examinations should not win the student advancement.

"The capacity to pass these intellectual tests should rank third in estimating the educational progress of a student," Dr. Butler declared. "Evidences of character-building should come first, and evidences of his good manners and respect and concern for others should come second; and, these lacking, no amount of intellectual performance of any kind should win him advancement or graduation. Such a one would not be educated at all; he would only have been instructed in some degree in the subject matter of a given field of knowledge."—American Nurses Association Bulletin, February, 1933.

# NIGHT DUTY

*By* CATHERINE D. de HUECK, Student Nurse, St. Michaels' Hospital, Toronto.

There is a subtle beauty in a hospital ward little seen by an outsider to whom it is nothing but a place of dreary suffering and dulling pain. Rooms, like people, have characters—the reflection of their owners. A ward is just a large room with many changing occupants, each leaving his or her indefinable something on its face: that is why wards in old hospitals are mellow, a little sad, very cosy in their own way, full of personality, for have not mighty dramas been played in them. Human courage has held its banner high and shown its radiant face amidst suffering and pain; heroic deeds have been performed, as they should be —quietly, unobstrusively; beauty of soul has been revealed so dazzling that those who witnessed it reflected, for a long time, its glory in their faces. Patience, fortitude, unselfishness, gratitude, are daily companions of the sick, stamping, reflecting themselves on the face of the ward. Have you seen it at sun-down when the setting rays light a brilliant fire in the polished window panes, drawing crazy patterns on immaculately white counterpanes, making medicine bottles shine and reflect their light in the tired eyes of the patients, bringing out the vivid colours of the flowers?

This is the time when the night nurse starts her duties. It is quiet then, the subdued feverish activities of a hospital day are over. The patients rest from whatever excitement it has brought to them. The night is not far—when one is sick darkness means perhaps fears, perhaps pain, always loneliness, and many are the eyes that follow the night nurse about her duties. Will she understand? Will she help? There is so much more to nursing than just nursing.

Number One is expecting a verdict, trying are her days with hard incomprehensible tests, what has the future in store for her? She is afraid, the night is long, "Nurse, Nurse, help me to fight my fear, help me to be brave in the face of uncertainty."

Number Five is a bewildered soul, a foreigner, who cannot speak English at all, frightened of the big stately ward, of the white robed doctors, the efficient nurses, homesick for her many children. She is like a little child lost in a big wood. Oh, the power of a smile, of a gentle voice, of a little friendly gesture.

Number Eight, an old woman with an incurable disease, facing the just-delivered verdict of her removal to the Home for Incurables. Is it to be wondered that she is cranky, that she grumbles and demands special attention, wearing the nurse out? A little patience will go such a long way; silence, when a sharp word is about to be spoken, will bring its reward a hundredfold.

Number Two is too sick to take notice. She, to-night, will only need the deft fingers, the trained mind that are the nurses stock in trade. The night is long, Nurse, do not allow your vigilance to relax—a life is in your keeping.

And so down the dimly lighted ward where the stretch of beds loses itself in semi-darkness, they are all numbered, but their occupants are neither "numbers" nor "only patients," they are "human beings in pain." The night is long, the night is dark, the only light is on the nurse's desk, let her remember it, for in that light she must be all things to all, and only then will she be a "good night nurse."

# Department of Nursing Education

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## THE REPRODUCTION OF PATHOLOGICAL SPECIMENS BY THE USE OF THE WAX MOULAGE

*By* HORTENSE P. A. DOUGLAS
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Wax moulage as a means of faithfully reproducing skin lesions, anatomical specimens, and variations from the normal on the body surface, has been in use for a great many years and has found a number of skilful exponents, many of whom have used a process which has never been divulged. The purpose of this paper is to describe the method of applying the process originated by Dr. Frank Wallis of the Army Medical Museum of Washington, to the reproduction in wax of fresh pathological material, as used in the Department of Pathology at the Montreal General Hospital, under the direction of Dr. L. J. Rhea.

Even the most carefully preserved pathological specimen loses a great deal in the fixing process, not only in detail and colour, but also in texture and size. The object of the wax moulage is not only to reproduce the fresh colour of the original specimen, but also its minute detail, as well as to maintain the appearance of plasticity and suppleness which is the distinguishing feature of tissue recently removed from the body. The dry, leathery shrunken appearance, for instance, of a formalin fixed portion of a human stomach, where the rugæ radiate from a dark craterlike ulcer, bears little resemblance to the velvety supple texture of the same specimen when fresh, with its loose mucosa thrown into soft folds around the brilliantly coloured, indurated area of ulceration.

To this end, the plaster impression is taken as soon as possible from the fresh specimen obtained from the operating room or post-mortem table. There are some fresh specimens which do not lend themselves to this procedure without preliminary fixation, such as very luxuriant pedunculated papillomata, or flat soft sessile growths, or tumours which have proceeded to extensive necrosis. Such specimens as these must be partially fixed in ten per cent solution of formalin for a short while before taking the plaster impression. Cystics tumours, hydro-nephrotic kidneys, in fact any cavities filled with fluid, must be distended with formalin to their original size and tension before opening, in order to give some rigidity to the walls. This fixing process must not be carried too far, a few hours is sufficient, or the resultant moulage will appear to be that which it really is: the reproduction of a fixed (rather than a fresh) specimen.

The greatest obstacle in the taking of any plastic impression is undercutting. This is particularly apt to be lost sight of in the reproduction of fresh specimens, which (in their soft condition) are so

easily drawn away from the set plaster, a proceeding which does not take place when wax is poured into a plaster cast. In order to avoid this, depressions with overhanging edges, such as are found in a large ulcer, or the dilated calices of a kidney, must be packed smoothly with oiled cotton, the defect so created to be remedied later by pushing back the wax before it has completely hardened immediately upon its removal from the plaster cast.

Before attempting to take the impression of a fresh specimen, such as the mucous surface of the stomach, it should be washed in saline to remove the blood, then immersed in a weak solution of sodium hydroxide to remove the mucos, rinsed again in saline to prevent disintegration of the mucous membrane, and carefully dried with absorbent cotton. It should then be laid on a board and surrounded by damp gauze, so as to eliminate undercuts at the edges, at the same time as nearly as possible reproducing the original contours of the organ. It is then lightly oiled with olive oil, and the plaster of Paris mixed to the consistency of thin whipped cream poured gently over the surface, care being taken to fill the lesion first so that the edges may not become unduly heaped up. As time here is no object, as it is in taking an impression from a living subject, it is not advisable to add salt to the water, as this sets the plaster too rapidly, producing a degree of heat sufficient to destroy the mucosa.

The finest dental plaster is used, as recommended by Dr. Wallis, and the basic wax formula is that which he originated. The plaster cast is allowed to dry out for several days at room temperature, then immersed in cold water for twelve hours, during which time the air bubbles escape, then dried before pouring the wax. The formula used is as follows, with variations as indicated by the specimens to be reproduced:—

2 lbs. white beeswax
1¾ lbs. paraffin
1 lb. talcum powder
1 lb. prepared cornstarch
2 oz. yellow beeswax.

Whenever possible the colour should be added to the fluid wax and it is always recommended that the basic colour, or the lightest tone appearing in the specimen (*i.e.* the delicate tint of the pelvis of a kidney) be noted and the wax tinted to that shade before pouring. Roehrig's transparent oil colours are used, a small amount of wax being melted down from the stock and coloured as the specimen requires. After the first coat of wax has been run over the plaster, the fat should be coloured yellow and as much colour added from the back as possible, owing to the fact that the tiny irregularities on the surface of the hardened wax catch the oil paint applied and present a granular appearance, which is to be avoided. A coating of white shellac is used to give the glistening effect of mucous membrane, and this should be sprayed on with a *fixatif* blower in order to achieve an even sheen. The shellac should be diluted with alcohol according to the degree of lustre required, a strong *fixatif* being enough for a serous surface.

When it is unavoidable that a lobulated and undercut surface be represented, it is recommended that a thin coating of wax be poured on the plaster cast, removed while still soft, smoothed with the fingers (rubber gloves should be worn) to the desired contours, and immersed immediately in ice water, more wax being added

later to the requisite thickness. The introduction of a metal probe into the model at the site of a perforated artery often adds realism to the specimen. Such an instrument should be filed to an appropriate length, heated and inserted a few millimeters into the wax at the desired point. Calculi should be well dried out, heavily shellacked for preservation and affixed to their original position on the moulage by means of balsam, which should be allowed to dry out well before handling. Moulages of specimens of nephrolithiasis and cholelithiasis prepared as above make most striking and instructive models.

The wax reproduction, when coloured and perfectly dry, must be mounted on a suitable board. Three or four short pieces of dental lead strips should be imbedded in the wax from behind, allowing them to project half an inch beyond the edge, by means of which the wax specimen is nailed to the board. It is then draped to conceal the edges with strips of linen, which should later be painted over with a thin coating of plaster of Paris in water, for preservation. A label with diagnosis, reference numbers, and a brief history, and a glass case over all to keep out the dust as well as to prevent handling, give a neat finish to the specimen.

In conclusion, this is a very simple and effective method of permanently preserving the graphic likeness of fresh pathological material. Its application is limited only by ingenuity; endless variations on the wax composition may be used, reducing the talcum and cornstarch proportions when reproducing bone; a drop of white beeswax tinted with yellow, added from a medicine dropper, may give the illusion of pus oozing from a small orifice; clear shellac applied in the same manner for serous fluid; and many other impromptu inventions that are called for as the occasion requires. As long as the unbroken plaster cast is at hand, the specimen may be reproduced long after its original has been demolished by the microtome.

# SANATORIUM AFFILIATION

*By* B. BIBBY, Matron, Tranquille Sanatorium, Tranquille, B.C.

Tranquille Sanatorium has been affiliated with the nurses' training schools of the general hospitals of British Columbia for two years. During this period, one hundred and seventeen student nurses have been given an intensive two months' course in tuberculosis. Classes of nurses from general hospitals replace each other at two month intervals. These classes have of necessity been comparatively small, varying from nine to thirteen students.

The course consists of lectures on the bacteriology of the disease, theories of infection, types of disease, symptoms, treatment and x-ray demonstrations by members of the medical staff, and lectures with demonstration of tuberculosis nursing by the superintendent of nurses and her assistant as well as practical nursing experience in the care of active tuberculous disease. Methods of protecting those who are well from the dangers of infection are stressed.

Efforts have been particularly directed to teaching the nature of the disease, its symptoms, spread, means of prevention, the possibilities of its cure and the psychological effect upon patients suffering from this far too prevalent disease.

The student nurses have responded well in most instances to the demands for adjustment from the intensively active duties of a general hospital to the quiet methodical routine of sanatorium life. They have shown, both in practice and examination, an intelligent grasp of the essential knowledge a nurse should have to enable her to properly nurse tuberculosis, and also to give the timely advice that is required to ensure an early diagnosis, by which the long inactivity necessary to the cure is often avoided.

The two months personal contact with a number of tuberculosis patients in varying stages of the disease has much to commend it rather than deeper theoretical knowledge and contact with olny a few advanced cases which may be a source of greater infection than in a sanatorium, where preventive methods and instruction against contamination are highly emphasized and practised.

Little or no disorganisation results in the change of student nurses' classes every two months. No doubt this has been aided by the fact that most of the student nurses have had more than one year's training in general hospital work. The majority have come to the Sanatorium in their third year of training.

All nurses do not show an aptitude for this branch of nursing, but they gain knowledge and experience that can be used to great advantage wherever the opportunity to do so arises.

# Department of Private Duty Nursing

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## PNEUMONIA

*By* Dr. TREVOR OWEN,
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Pneumonia is the situation, par excellence where we are treating the patient, rather than the actual infection or the lesion in the lung. Except in possibly one variety of pneumonia (Type 1—pneumococcic pneumonia where a serum may be tried) we have no direct specific method of attacking the organism causing the disease. The problem then is how to assist the patient to weather the storm. We all know that an experienced nurse, with an imagination, is the best assistant. By imagination I mean that quality of being able to realise the patient's discomfort at the moment, to foresee what it will be at the next, and to invent and carry out a hundred and one tricks to allay or forestall it, and all without ostentation or conversation. By this unflagging watchfulness, incalculable effort and strength are conserved so that they will outlast the life of the infecting organisms. It is my purpose to reiterate the reasons for the principles of treatment, so that those who nurse these patients may have their imagination fired with interest and understanding.

Cases of pneumonia may be divided roughly into three large groups:

1. A short severe illness
2. A long severe illness
3. A long comparatively mild illness

*First Group—A Short Severe Illness*

This is the typical case of acute lobar pneumonia, due to one of the four groups of pneumococcus, and lasting from three to ten days or so, barring complications. Occasionally, other organisms, such as the streptococcus, will give this picture.

Now what happens in this patient and what does he actually suffer from? It is to be remembered that the shortness of breath is not due to the fact that part of the lung is out of commission. It is due to the fact that the pneumococcus produces a toxin which is peculiarly injurious to the heart, blood, and blood vessels. This places the patient at a great disadvantage in coping with the infection, especially as the high fever necessitates a large supply of oxygen, due to the very high basal metabolic rate.

The toxin's effect on the blood vessels in the limbs and in the splanchnic area is of great importance. Because of this injury, the vessels dilate, the blood flow is slowed, too much oxygen escapes from the blood, so that on its return to the lungs, the time ordinarily allowed in the lungs is insufficient to renew the supply to the normal percentage. Added to this is the fact that the blood returning from the pneumonic area, has not only been deprived of its contact with air but has passed through the area of greatest concentration of toxin. The patient, therefore, is really suffering from a blood supply to his brain, heart, and blood vessels generally, which is not only deficient in the substance

the tissue cells require most, but contains a highly poisonous material, viz., pneumococcic toxin. Our object then in treatment is to be directed towards alleviating this state of affairs.

We must get rid of the toxin continuously and promptly by bowels and kidneys, and dilute it by giving enormous quantities of water. We must supply the cells with that material which will be of most use to them with the minimum of work on their part, and which will prevent, to some extent, their damage by the toxin. This material is sugar, the quickest and most immediately usable source of energy. The corollary of this is that we prevent the patient from using his brain, his heart and his blood vessels, except for the essentials of existence — breathing, swallowing and excretion. We do this by silence, isolation, and attendance. By silence I mean no unessential light talk by nurses, doctors or visitors — there should be no visitors. By attendance is meant the constant prevention of any muscular effort on the patient's part. He should not have to reach for a sputum cup or hold a drinking tube.

The use of oxygen to overcome the cyanosis is not one of the responsibilities of the nurse, so that it is outside the purpose of this article, except to mention that the oxygen tent is the only satisfactory method of administration. The holding of a funnel in front of the patient's face is more or less useless, and the nasal catheter method a poor substitute for a tent.

As mentioned above, in the short severe illness, sugar and water are the essentials. The patient can afford to do without protein and fat until convalescence has commenced. The abdominal distension, that is often a distressing feature, is probably due to the effect of the toxin on the intestinal muscles and nerves and not to the large quantities of sugar taken. The bowels must be moved once a day by simple enemata.

*Second Group—A Long Severe Illness*

To this group belong those pneumonias due to the streptococcus, sometimes to the pneumococcus, and frequently a mixed infection. The important point in which these differ is the fact that the patient must have more protein. That is to say, after ten days have passed, the intake of sugar and water must be augmented by protein, since the wastage of body tissues must be replaced. The remarks made under the First Group heading as regards silence, isolation and attendance, of course apply here, too.

*Third Group—A Long Comparatively Mild Illness*

The mildness is due to the less toxic nature of the infection and the importance of sugar and water is correspondingly less. The intake of a general mixed diet with plenty of protein is essential. Foods which have small bulk in comparison with their caloric value should be chosen.

*What to Watch For in Pneumonia*

1. Changes in colour may mean the failure of the peripheral vascular bed or heart failure.

2. Irregularities in the pulse. The onset, for example, of a complete irregularity means auricular fibrillation due to severe poisoning of the heart muscle.

3. Severe chills usually mean a septicaemia with spread of the pneumonia to a new area.

4. When pleuritic pain is severe one fears the possibility of an empyema.

5. Cheyne - Stokes respiration means the damage to the vascular system is affecting the circulation in the brain.

# Department of Public Health Nursing

## HOW THE PUBLIC LOOKS AT PUBLIC HEALTH NURSING

*By* Mrs. H. P. PLUMPTRE, Toronto, Ontario.

It is quite unnecessary to define "public health nursing" to this audience, but I wish the audience would define it authoritatively—to me—who, however inadequately, am representing this morning: "the public!"

I find that you yourselves, in the Report of the Survey of Nursing Education in Canada, are asking whether nursing is a profession, and if you, the experts, are still asking that question, you must not be too hard on the public which is still a step or two behind you in this matter. For many of us are still asking "what is public health?" and I find a considerable variety of opinion on this subject among people of my own acquaintance.

Here are a few answers:—

1. Public health means the health of the community as opposed to the health of the private individual.
2. Public health service is a service supported by publicly collected funds (taxes) and administered by publicly appointed officials.
3. Public health is preventive and not merely curative.
4. Public health means healthful environment.
5. Public health nursing is not really nursing at all; it is a camouflage to call it nursing; it is really the teaching of hygiene; and it is called nursing because people are more in favour of nursing than teaching and so it is more easy to get it paid for out of the taxes.

As no paper on nursing is complete without a reference to Florence Nightingale, I will add her definition of it: "nursing the well"; and if we go back to the primary meaning of the word *nurse*, which is closely connected with food, we find ourselves including in public health, the very necessary idea of proper feeding.

Therefore I would submit that the public looks at public health nursing with a certain amount of uncertainty as to its outlines, and that an authoritative definition of public health and of public health nursing would be warmly welcomed by us.

But the public is not an individual, but rather a composite of groups. If you look at it carefully, you will see many persons; if you listen, you will hear many voices, all speaking at once and all saying different things. If I tried to combine them, the result would be only a hideous confusion, so I will try to distinguish and relay them to the audience.

I see in the forefront, *the taxpayer*. For our purposes, he is the descendant of the economic man of the older economists who feels only through his pocket. He looks at public health nursing as the latest fad devised to deplete his "wad",

(Address given at the Public Health Nursing Section of the Canadian Public Health Association Annual Meeting, 1932, also, published in The Canadian Public Health Journal, October, 1932.)

or the latest frill to empty the tradesman's till. He sees it as a potential mill on the dollar in the tax-rate; and he asks, with perfect justification, I think, "What right has anyone to add even a straw to the tremendous burden of taxation which we have already imposed upon us?"

I would venture to suggest that the way to meet this gentleman is with a persistent and steady drip of information as to the cost of public *ill-health*. Once convinced that it costs a community more to be ill than to be well, he will be satisfied to pay even the extra mill on the dollar. The cost of an epidemic occurring this year may be so used as to have a distinct and direct influence on the health budget of the community next year—but only if it is clearly and often explained in the press, and on platforms, and in pulpits, and made the subject of questions at election time.

I see also the *individualist*. He looks back to the days when there were no provisions for health, except those made, according to their conditions, by each household. He dislikes "molly-coddling" in any form; he loves independence of mind and body. He certainly has some justification for his fears. We have all seen, with regret, a tendency to demand service *from* the state without a counterbalancing desire to render service *to* the state. But can we be individualistic or independent in this matter of health? In self-defence, if for no altruistic motive, we need the regulation of public health in our modern communities, and of this public health nursing is the practical application to the community.

I see also the *conscientious objector*, whose religious faith or racial prejudices make him eye with disfavour any attempt to coerce him against his will. What is to be done with him, or her? Again, I think a steadily-repeated, simply-expressed statement of the achievement of public health in reducing infant and maternal mortality, in saving child life and so on, with a tactful and sympathetic effort to make the invasion of his liberties as light as possible.

Also, I can hear the *conscientious critic*. He has known a case in which a public health nurse prescribed for a patient, perhaps only an aspirin or a hot water bottle. Public health nursing is therefore an unauthorized invasion of the physician's territory; a nurse should nurse, and not try to be a "half-baked doctor" or a "hard-boiled" one either. I am sure the public is with the critic in his views, and I am also sure he is expressing the views of the nursing profession in this matter—but we should not judge a stocking only by its holes.

I hear a perfect chorus of voices saying that a nurse should be a ministering angel, and ready when pain and anguish wring the brow, but that they really feel doubtful about all these clinics and classes. Ladies and gentlemen, you must always remember that the public *feels* far more than it *thinks!* How often we hear and say: "I *feel* that we should do this or that." It is for this reason that bedside nursing has such a tremendous appeal to the public. I *know* all about its being better to build a fence at the top of the cliff than to send an ambulance to the bottom, but I *feel* that there is a certainty about the need for an ambulance that there is not about the fence. Perhaps, after the fence is built, no one will walk in that direction; and, perhaps, if there had been no fence they would not have fallen over; and, anyhow, there is always the thrill when the ambulance bell is ringing! Preventive work appeals

to the emotions and instincts. The public loves to *feel* and hates to *think,* and so we are a little suspicious of a nurse who lectures instead of poultices.

When I began to think seriously about the preparation of this paper I thought of two or three things I should do. First of all, I thought I would find an authoritative definition of public health nursing in a dictionary. I tried four of them but not one of them even had the thing listed at all! The Oxford Dictionary, however, said that *the public* meant *the members of the community in general;* as for instance: "the public is the best judge!" I am grateful to the dictionary for this illustration. "The public is the best judge!" Here is a crumb of comfort from an authoritative source: "The public is the best judge!" And then I discovered that in the *Survey of Nursing Education in Canada*—to which I betook myself after the dictionaries had failed, it was stated that the attitude of the public was 59% ideal towards public health nursing. Well, I think it is something to be even 59% ideal in any atitude!

I am glad to see that the compilers of the *Survey* concede that the majority of the public are in favour of public health nursing. In spite of all the criticisms and objections I have passed on to you, I am sure that you have a steadily-growing majority in your favour. There are thousands of homes in which the beneficial results of public health nursing have been experienced and where its value is recognised. There is a growing volume of instructed opinion behind this work in spite of the fact that, in this time of financial distress, economies are apt to take strange directions.

In the *Survey,* I find that a quotation from an eminent authority to the effect that public health nursing is a new profession, and that the educational authorities have not as yet the faintest conception of the work, and we are doing our best to educate them. That's the spirit, ladies and gentlemen!

### JESSIE ROSS ROYER
### 1881—1932

Public health nurses in Canada have learned with regret of the death of Jessie Ross Royer, R.N., which occurred on October 2, 1932. Mrs. Royer graduated in 1904 from the Training School for Nurses, General Hospital, Wilkes - Barre, Pa., following which she was actively engaged in public health and child welfare work in Pennsylvania until 1920. Many will remember Mrs. Royer as Chief Nurse of the Massachusetts-Halifax Health Commission. Following her marriage in 1923, Mrs. Royer became associated with the American Child Health Association in an evaluation of public health, social and child welfare activities in several representative cities. Subsequently, as Staff Associate of the National Society for the Prevention of Blindness, she was instrumental in developing a technique by which accurate measurement of visual acuity in children as young as three years of age can be obtained, and in demonstrating this new idea lasting impressions remained with all who witnessed Mrs. Royer's ability.

# News Notes

## ALBERTA

The Edmonton branch of the Public Health Section of the Alberta Association of Registered Nurses has arranged with Dr. Smith of the University for a course of twenty lectures on Psychology and Mental Hygiene which started January 5th. Invitations were extended to other groups of nurses including staff nurses in hospitals. The Committee is very pleased with the interest shown in this course.

## BRITISH COLUMBIA

JUBILEE HOSPITAL, VICTORIA: At the social evening of the Alumnae Association on October 17, 1932, a fashion parade and musical programme were presented. On November 14, the members were entertained at court whist and bridge, and at the close of the evening Miss K. E. Oliver, immediate past president, was presented with a sterling silver brush. Miss Oliver's marriage to Arthur W. Aylard took place early in December. The regular business meeting of the Association was held in the Nurses' Home, on December 12. Plans for holding raffle were discussed. As the social evenings have been very successful, the Association is arranging for similar meetings in 1933.

## MANITOBA

BRANDON: The Graduate Nurses Association met in regular session on December 6, 1932, at the Nurses' Home, Mental Hospital. Fifteen dollars was donated to the Citizen Welfare League, for Christmas cheer and $5.00 to the Institute of the Blind. Dr. T. A. Pincock was the speaker of the evening, his topic being Prevention of Mental Diseases. Later Dr. Pincock conducted the members on a tour of inspection of the Women's Pavilion, a new building which opened early in December, 1932.

WINNIPEG GENERAL HOSPITAL: Miss M. Frosst (1907) has left Winnipeg to reside in Kingston, Ont.

## NEW BRUNSWICK

ST. STEPHEN: Miss Grace Moffat, Supt. Chipman Memorial Hospital, has returned from her vacation in Montreal. Miss Hazel Darker, Operating Room Supervisor, is spending her vacation in Sherbrooke, P.Q. and Miss Sarah Forbes (C.M.H.) is in charge of that department during her absence. Sincerest sympathy is extended to Miss Inez Holt, in the sudden death of her mother during the Christmas season.

## ONTARIO

### DISTRICT 2 AND 3

VICTORIA HOSPITAL, LONDON: The regular monthly meeting of the Alumnae Association which was held at the Gartshore Residence on January 3rd was marked by a very special feature—the presentation to the Association of the Charter of the recently organised Benefit Fund Society. The Charter was presented by Mrs. Hedley Smith, Convener of the Committee for 1932 and was received by Miss Hilda Stuart, Honorary President, of the Association and Superintendent of Nurses, Victoria Hospital. In accepting the Charter Miss Stuart expressed the appreciation of the Alumnae members to Mrs. Smith and her Committee for their efforts in bringing this work to a successful completion, and the thanks of all nurses who will receive benefits through the Mutual Benefit Society. Greetings and wishes for success were expressed by the Rev. Mr. Young, Dundas Centre United Church and by St. Joseph's Hospital Alumnae Association, through their President, Miss Connelly.

BRANTFORD: Keen interest is being shown in the Home Nursing Classes being conducted by the Brantford Branch of the Canadian Red Cross Society. Several classes are now in progress; the teachers are: Miss Hazel Diamond, Brantford General Hospital, and Miss H. Kerr, V.O.N. It is expected that two or more classes will start in the very near future. Lectures will be given by the doctors and will include:—Emergencies, Dr. R. W. Knight; Communicable Diseases, Dr. W. L. Hutton, M.O.H.; and Infant Care, Dr. G. W. Harris.

BRANTFORD GENERAL HOSPITAL: Miss Aileen Mair, (1926) of Brooklyn, N.Y., and Miss Florence Westbrook, (1921), of University of Michigan Hospital, Ann Arbor, spent the Christmas season in Brantford. Miss Alberta Bartley, (1922) was a recent visitor in Brantford. Miss E. M. McKee, Superintendent, Brantford General Hospital, was a New Year's visitor at her home Knowlton, Que. The Florence Nightingale Association met at the Brantford General Hospital, December 5, to make favours for the patient's trays. Following the meeting, refreshments were served by Miss McKee assisted by Misses J. M. Wilson and C. E. Jackson.

The monthly meeting of the Alumnae Association was held in the Nurses' Residence on December 6th. Miss K. Charnley presided. The guest speaker of the evening, Dr. R. W. Knight, gave a very interesting address on Indigestion. At the close of the meeting a social hour was spent.

GUELPH: The Kaufman Nurses' Residence at the Kitchener and Waterloo Hospital was the scene of a delightful event when the Kitchener Ladies' Auxiliary of the Hospital entertained there at a Christmas dance for the nurses-in-training. Mrs. C. D. Welch and Miss K. Scott received the guests. Mrs.

James Jaimet was the general convener of the event, assisted by Mrs. A. L. Campbell, Mrs. R. D. Morrison and Mrs. J. L. Holtze.

An unusual event took place at the Kaufman Nurses' Residence, Kitchener and Waterloo Hospital, when photographs of the donors of the institution, Mrs. Kaufman and the late Jacob Kaufman, were presented to the Residence, Mr A. R. Kaufman making the presentation. A large number of local citizens interested in the development of the Hospital were in attendance for the happy occasion. Dr. J. H. Honsberger gave an address on the history of the Hospital in Kitchener. At the conclusion of the addresses refreshments were served by he nurses.

STRATFORD GENERAL HOSPITAL: A full attendance greeted Miss E. Brown, missionary nurse, when she addressed the members of the Alumnae Association, on her work at the hospital at Chissambi, in Angola, West Africa. Interesting slides were shown by the speaker which made it an evening to be remembered. Refreshments and a social hour closed the meeting.

### DISTRICT 4

ST. JOSEPH'S HOSPITAL: The Alumnae Association met on December 1, 1932, Miss A. Quinn presiding. Reports were given and officers for the year 1933 elected. A vote of thanks was tendered to the retiring officers. The Association reports with pleasure that Miss Anne Reid has sufficiently recovered to be dismissed from the Sanatorium. A very largely attended charity bridge and euchre party was held at Undermount on November 21st under the convenership of Miss Louise McIlhone. Prizes were presented and a dainty luncheon served.

### DISTRICT 5

GRACE HOSPITAL, TORONTO: The usual work of providing some Christmas relief was undertaken again by the Grace Hospital Alumnae Association. This year twelve needy families, consisting of seventy-seven people, were secured through the Neighbourhood Workers. Personal gifts were provided for each individual in addition to the well-filled baskets.

At the regular monthly meetings of the Grace Hospital Alumnae Association since the opening of the season the following speakers addressed the meetings:—

OCTOBER, Miss Alberta Bell gave an excellent report of the Biennial Meeting of the Canadian Nurses Association in St. John.

NOVEMBER, Dr. Dennis Jordan gave a lecture on Post-Operative Treatment and showed interesting pictures of his recent visit in Europe.

DECEMBER, Mrs. C. J. Currie read a paper on Mission Work in India.

JANUARY, Dr. Cameron A. Warren lectured on Community Health Problems.

The nurses greatly appreciate having these addresses and it is found that the attendance is stimulated by having such out-standing speakers.

The February meeting will be a social one and will take the form of a Bridge.

TORONTO GENERAL HOSPITAL: Among those present at the annual dinnner of Class 1916 were Mrs. Aldred, Mrs. Livingstone, Mrs. McNaught, Mrs. Moorehead, Mrs. Angus Mackay, Mrs. Carpenter, Mrs. McLean, Mrs. Delaporte, Mrs. Witherspoon, Mrs. Mountain, Mrs. Wagg, Misses Castle, Murray, Seale, Law, Moon, Charles, Agar, Matheson and Squires. Mrs. Carpenter is the new president, succeeding Mrs. Clarke, who has moved to Peterborough, and Miss Seale continues as treasurer. Fifteen dollars was voted toward the Star Santa Claus Fund.

ST. MICHAEL'S HOSPITAL, TORONTO: Miss Elizabeth McGauley, who completed a post-graduate course in obstetrics has been appointed to the staff of the Hospital.

WOMEN'S COLLEGE HOSPITAL, TORONTO: The final meeting of the Alumnae Association for 1932 was held at the Clinic House where, after a short business session, Miss Margaret Gould, representing the Local Council of Women, gave an address in which she urged the nurses, when qualified, to register for the municipal vote. She proved in a convincing way that elections should be held the beginning of December as New Year's Day is one on which the voter and home maker wishes to dispense hospitality at home; also the budget could be completed at the end of January instead of on March first. Miss Gould pointed out that health conditions could be improved if more consideration was given that subject.

Owing to the absence of the President, the January meeting was conducted by the Vice-President and took the form of a social hour during which several members gave talks on continental travel. The many friends of Miss Blair will be pleased to learn that she is making an excellent recovery following a recent operation.

### DISTRICT 6

The annual meeting of Chapter 3, District 6, R.N.A.O. was held at Nicholl's Hospital Residence, November 29, with Miss Dixon in chair. Nine meetings have been held during the year 1932, and were well attended, indicating a lively interest in the progress of the Chapter. The Chapter is open to all registered nurses, who are members of the R.N.A.O. Nurses who are not in active practice are eligible as guest members . The members of the R.N.A.O. attached to the Chapter in Peterboro are 14, guest members 19. At the meetings, the important part of the pro-

gramme has been the study of the various Chapters of the Survey Report. Reports from the different committees were heard, and a very satisfactory report from Chapter C (Lindsay). A social hour brought the meeting to a close.

PETERBORO: The Nicholls Hospital Alumnae Association held their annual banquet, in the Empress Hotel, on December 14, being attended by many out of town graduates. The guest speaker for the evening, Dr. Hammond, gave an interesting talk on "The Medical Men of the Early Days of Peterboro". After the toasts, the guests spent the remainder of the evening playing bridge.

It is with deep regret we record the death of one of our members, Miss Lillian Simons, whose sudden passing on the afternoon of December 24, was a great shock to her many friends in Peterboro. Miss Simons will be greatly missed in local nursing circles as she took a most keen interest in all nursing problems. She has served a number of terms most efficiently as Secretary-treasurer of District No. 6. Miss Simons was a graduate of St. Mary's Hospital, Rochester, N.Y.

### QUEBEC

JEFFREY HALE'S HOSPITAL, QUEBEC: The annual Christmas tree of the Jeffrey Hale's Hospital, was held in the Nurses' Residence, on December 21st. There was a large attendance of patients, hospital staff, graduates and friends of the institution. Following the programme of entertainment, which included Santa and his pack of gifts and candies for all, dancing and refreshments were enjoyed. Miss Ethel Douglas, Supervisor of the "Douglas Wing" who has been a patient in the Hospital for some time, is improving. During her illness her position has been filled by Miss Riglar. The sympathy of the Association is extended to the Misses Effie, Mildred and Doris Jack in the loss of their mother, also, to Miss Gladys Weary in the loss of her mother.

THE MONTREAL GENERAL HOSPITAL: Miss Bessie M. MacMurchy, a graduate of the Training School, left in September, 1932, to enter the Bhil field in India as a missionary nurse.

### SASKATCHEWAN

GREY NUNS' HOSPITAL, REGINA: The December meeting of the Alumnae Association was held at the home of Mrs. Fyfe. There was a good attendance and reports from all committees were given. Nominations for 1933 officers were presented.

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## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

ADAMS—Recently, to Dr. and Mrs. Adam, Cabri, Sask. (Demarni Riche, Grey Nuns' Hospital, Regina, 1923), a daughter.

BOWLES—On November 26, 1932, to Mr. and Mrs. Louis Bowles (Marie Robbins, St. Michael's Hospital, Toronto, 1924), a son.

BURGAR—In December, 1932, to Mr. and Mrs. Burgar (Ada Kennedy, Toronto General Hospital, 1918), a son.

BURGESS—On December 21, 1932, at Victoria, B.C. to Mr. and Mrs. E. H. Burgess (Dorothy Head, Jubilee Hospital, Victoria, 1927), a daughter.

CAMERON—Recently, to Mr. and Mrs. Cameron (Miss Gahl, Grey Nuns' Hospital, Regina, 1931), a daughter.

CURRY—On November 9, 1932, at Victoria, B.C., to Mr. and Mrs. H. Curry (Marjorie Morrison, Jubilee Hospital, Victoria, 1928), a son.

DEACOFF—On November 26, 1932, at Toronto, to Mr. and Mrs. James M. Deacoff (Helen Christina Thurlow, Grace Hospital, Toronto, 1927), a daughter, (Marylyn).

GUNN—On December 7, 1932, at Fort Francis, Ont., to Dr. and Mrs. Lynn Gunn (Melrose King, Winnipeg General Hospital, 1925), a son.

HAMILTON—On January 2, 1933, at Davenport, Iowa, to Mr. and Mrs. J. Hamilton (Helen Gugin, Winnipeg General Hospital, 1929), a son.

JOHNSON—Recently, at Vancouver, B.C., to Dr. and Mrs. A. Johnson (Kathleen Walsh, Grey Nuns' Hospital, Regina, 1920), a daughter.

KEYS—Recently, at Regina, Sask., to Mr. and Mrs. Thos. Keys, (Mary Anderson, Grey Nuns' Hospital, Regina, 1929), a daughter.

LAMBERTUS—On November 15, 1932, at Cargill, Ont., to Mr. and Mrs. Gordon Lambertus (Adelaide Commerford, St. Joseph's Hospital, Hamilton), a son.

LESTER—On October 15, 1932, at Guelph, Ont., to Mr. and Mrs. Clarence Lester (Laura Byrne, St. Joseph's Hospital, Hamilton), a daughter.

MacCANN—On August 26, 1932, to Mr. and Mrs. Angus MacCann (M. Brocklebank, Wellesley Hospital, Toronto, 1925), a daughter.

McCOLLUM—On November 9, 1932, to Mr. and Mrs. Fred McCollum (K. Blair, Wellesley Hospital, Toronto, 1926), a son.

McEACHREN—On August 9, 1932, to Mr. and Mrs. R. S. McEachren (Florence Cluff, Montreal General Hospital, 1923), a daughter.

McGEE—In July, at Toronto, Ont. to Mr. and Mrs. Murray McGee (Ruth Devlin, St. Michael's Hospital, Toronto, 1930), a daughter.

METCALFE—In December, 1932, to Mr. and Mrs. Metcalfe (Harriet Towne, Toronto General Hospital, 1921), a son.

RATHBONE—On November 12, 1932, to Mr. and Mrs. Walter Rathbone (E. Hanna, Wellesley Hospital, Toronto, 1923), twin sons.

WALLIS—On October 31, 1932, at Shanghai, China, to Mr. and Mrs. P. R. M. Wallis (Jean Paterson, Jubilee Hospital, Victoria, 1927), a son.

WRIGHT—On June 4, 1932, to Mr. and Mrs. Leslie Wright (Ellie Henrikson, Montreal General Hospital), a son.

## MARRIAGES

AMOS—PARMENTER—On June 6, 1932, at Montreal, P.Q., Helen Parmenter (Montreal General Hospital, 1924) to Pierre Chas. Amos.

AUCKLAND—JACKSON—On November 14, 1932, at Toronto, Ont., Ruth Jackson (Wellesley Hospital, Toronto, 1925) to Ernest Auckland, Speers, Sask.

AYLARD — OLIVER — On December 19, 1932, at Victoria, B.C., K. Elsie Oliver (Jubilee Hospital, Victoria, 1928) to Arthur W. Aylard, of Sidney, Vancouver Island, B.C.

BAUMGARTNER — MESSMORE — On October 3, 1932, at Clifton Springs, N.Y., Margaret Messmore (Instructors and Administrators Course, University of Toronto, 1932) to Dr. E. A. Baumgartner, of Clifton Springs, N.Y.

BELL—EASTWOOD—On December 12, 1932, at Toronto, Ont., Kathleen Eastwood (St. Andrews Hospital, Midland, 1931) to Sam Bell, of Midland, Ont.

CAREW—CONRAD—On August 31, 1932, Christina A. Conrad (Montreal General Hospital) to Maurice C. Carew.

CARTER—WARREN—In November, 1932, at Victoria, B.C., Helen Warren (Jubilee Hospital, Victoria, 1930), to Clement Carter, of Port Haney, B.C.

COX — METHERAL — On December 30, 1932, at Crossfield, Alberta, Greta Metheral

CAMERON—McDONALD—On December 21, 1932, at Toronto, Frances Myrtle McDonald (Grace Hospital, Toronto, 1919), to Dr. Gordon C. Cameron, Toronto.
(Royal Alexander Hospital, Edmonton, 1929) to George J. Cox, of Edmonton, Alta.

DALY—BOND—On August 6, 1932, at Toronto, Ont., Cecilia Loretta Bond (St. Michael's Hospital, Toronto, 1932) to Maurice James Daly.

DUFOR—LANE—On November 29, 1932, at Hamilton, Ont., Kathleen Lane (St. Joseph's Hospital, Hamilton) to V. DuFor, Hamilton, Ont.

FESSENDEN—STEELE—In May, 1932, Clara Martha (Queenie) Steele, Black Cape, P.Q., (Montreal General Hospital, 1924) to Clifford C. Fessenden.

FITCH—BROWN—In September, 1932, at Vancouver, B.C., Vera Brown (Jubilee Hospital, Victoria, 1929) to Herbert Fitch, of Seattle, Washington.

GARRISON—WATSON—On June 20, 1932, at Brantford, Ont., Helen Watson (Montreal General Hospital) to Lieutenant Flint Garrison, U.S.A. Air Corps, Detroit, Mich.

HICKEY—KNOWLTON—On June 1, 1932, Toronto, Ont., Adele Marie Knowlton, (St. Michael's Hospital, Toronto, 1929) to Leo Joseph Hickey.

HUNTER—COLE—On November 10, 1932, Cora Margaret Cole (Grace Hospital, Toronto, 1923), to Vernon Hunter, Cavan, Ont.

KILLINGSWORTH — RUSSELL — On July 12, 1932, at Toronto, Ont., Edith Claire Russell (St. Micahel's Hospital, Toronto, 1929) to Edward Killingsworth.

LESTER — CANDLISH — On August 11, 1932, at Montreal, P.Q., Thelma C. Candlish (Montreal General Hospital) to Rev. Harold G. Lester, B.A., B.D.

LITTLE—MONTAGUE—On November 5, 1932, at Victoria, B.C., Bertha M. Montague (Jubilee Hospital, Victoria, 1928) to Thomas M. Little, of Victoria, B.C.

LOWE—CLARKSON—On October 25, 1932, at Victoria, B.C., Alice Clarkson (Jubilee Hospital, Victoria, 1929) to Benjamin Lowe, of Port Alberni, B.C.

MAUNDER—BRASS—On October 15, 1932, at Lindsay, Ont., Ola Mary Arline Brass (Grace Hospital, Toronto, 1930), to Clifford Leigh Maunder, Lindsay, Ont.

SMITH—COLE—On December 10, 1932, at Niagara on the Lake, Ont., Evelyn Cole (Wellesley Hospital, Toronto, 1925) to H. L. Smith, D.D.S., of Toronto, Ont.

STANBRIDGE—HARCUS—On December 10, 1932, at Stonewall, Man., Jessie Harcus (Winnipeg General Hospital, 1931) to James Stanbridge.

THURESSON—ALGIE—On November 22, 1932, Jessie Algie (Toronto General Hospital, 1921) to Henderson Thuresson.

TUCK—WRIGHT—In November, 1932, Rhea Wright (Toronto General Hospital) to Mr. Tuck.

WASHINGTON — ARNOLD — On January 3, 1933, at Wadena, Sask., Bertha Arnold (Winnipeg General Hospital, 1925) to Dr. L. A. Washington.

WIGHT—SMITH—On December 31, 1932, at Lachute, P.Q., Blanche Janet Smith (Montreal General Hospital) to Ralph Albert Walter Wight.

WRIGHT — FRASER — At Glensamfield, Ont., Sarabel Fraser (Montreal General Hospital) to Dr. Chas. Burton Wright, Calgary, Alta.

DEATHS

GRIFFITHS—On August 23, 1932, at her late residence, 4552 Oxford Ave., Notre Dame de Grace, Montreal, P.Q., Helen Grace Pyke (Montreal General Hospital, 1915), beloved wife of Evan P. Griffiths.

SIMONS—On December 24, 1932, at Peterboro, Ont., Lillian Simons (St. Mary's Hospital, Rochester, N.Y.).

SUNLEY—On December 25, 1932, at Rochester, New York, Ida M. Sunley (Rochester General Hospital), beloved daughter of Mrs. Elizabeth Sunley and the late James B. Sunley, of Toronto, Ont.

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## THE IDEAL NURSE

The Ideal Nurse must be healthy in both mind and body. She must be absolutely loyal to the Profession as a whole; and to her patients. Obedience is one of the essential qualities; she must always obey orders and be reliable, thus gaining the confidence of patients, friends, doctors and instructors. She must have the ability to adjust herself to new situations, be ready for emergencies, and be capable of handling people well.

She must possess the true spirit of service to humanity and the spirit of love which overcomes all difficulties.

She must be skilful with her hands; her touch, gentle but firm. She must express herself accurately and concisely, either in writing or verbally. She must have a good memory, which may be cultivated by close interest and attention. Her sense of sight, hearing, smell, taste and touch must at all times be alert and accurate. Her nerves must be steady and controlled. She must have good foresight, initiative, judgment and common sense.

The Ideal Nurse is one who can manage several things successfully at once and keep things running smoothly. The Ideal Nurse is cheerful and optimistic but not frivolous. She possesses a spirit of appreciation of work well done; of the science of nursing and of the progress and recovery of a patient. She gives the same care to all patients, regardless of sex, race, creed, friends or enemies.

She is ready at all times to give her services. She is keenly interested in nursing and medical work. She does all her work faithfully and well, whether the task be menial or otherwise, and thus tries to make the most of her life in her service to humanity.

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*A probationer in the School of Nursing of the Victoria Hospital, London, Ontario, is responsible for this admirably phrased concept of nursing. The younger generation kindles a new torch from an ancient flame.*

Institute of Public Health
Faculty of Public Health of the University of Western Ontario
LONDON - CANADA

# THE CANADIAN NURSES ASSOCIATION CONGRESS TOUR

Recently an attractively illustrated booklet relative to the Canadian Nurses Association Congress Tour was issued by Thos. Cook and Son, who are the Official Travel Agents for the Canadian Nurses Association in making travel arrangements for nurses from Canada to the International Council of Nurses' Congress.

Dates of the Congress: Paris, July 10-12; Brussels, July 13-15, 1933.

Sailings from Canada can be made on any Canadian Pacific steamship. Members joining the Main Tour will sail on the Empress of Britain from Quebec City on July 1st. This is a 21-day tour and allows for four days in London following the close of the Congress. The cost is $267.00. Other convenient sailings are: (1) The Montrose, from Montreal, on June 21st, and (2) the Empress of Australia, from Quebec, on June 28th.

Among tours included in the illustrated booklet are:

1. France, Belgium, Germany, the Rhine and Switzerland, 35 days—$341.00.
2. Number 1, with England included—$371.00.
3. Number 2, with extension to the Italian lakes, French Riviera and through the Alps, 47 days—$437.00.
4. France, Belgium, Germany, the Rhine, Czecho-Slovakia, Austria and Switzerland, 47 days—$506.00.
5. France, the Chateau Country, Paris, Belgium, England, 38 days—$318.00.

Further information for these tours and several others can be obtained from Thos. Cook and Son. Branch offices in Canada: 1455 Union Avenue, Montreal, P.Q.; 65 Yonge Street, Toronto, Ont.; 554 Granville Street, Vancouver, B.C. See also *The Canadian Nurse,* December, 1932, and January, 1933.

Immediately following the Congress of the International Council of Nurses, the Dutch Nurses' Association (Nationale Bond van Verplegeden) are arranging a trip through Eastern Holland to last about one week, the cost of which will be about 75 guilders — approximately $30.00. Details of this trip are not yet available, but the Province of Drente will be visited, and the excursions will be arranged so that they are interesting from the professional as well as from the sight-seeing point of view. Those wishing to take this trip, or that from July 4th to 8th, are asked to communicate as soon as possible with the Nationale Bond van Verplegenden, Roemer Visscherstract 1, Amsterdam W.

To those fortunate travelers who intend to explore Holland, the article published on page 68 of this issue will serve as a practical guide. Those who must stay at home will read it with interest because of the charming glimpse it gives of Dutch hospitals and Dutch nursing.

# Official Directory

## INTERNATIONAL COUNCIL OF NURSES

**Secretary**.....Miss Christiane Reimann, Headquarters: 14 Quai des Eaux-Vives, Geneva, Switzerland.

## EXECUTIVE COMMITTEE, CANADIAN NURSES ASSOCIATION

### Officers

**Honorary President**.....Miss M. A. Snively, General Hospital, Toronto, Ont.
**President**.....Miss F. H. M. Emory, University of Toronto, Toronto, Ont.
**First Vice-President**.....Miss R. M. Simpson, Parliament Bldgs., Regina, Sask.
**Second Vice-President**.....Miss G. M. Bennett, Ottawa Civic Hospital, Ottawa, Ont.
**Honorary Secretary**.....Miss Nora Moore, City Hall, Room 309, Toronto, Ont.
**Honorary Treasurer**.....Miss Margaret Murdoch, St. John General Hosp., Saint John, N.B.

### COUNCILLORS

**Alberta:** 1 Miss F. Munro, Royal Alexandra Hospital, Edmonton; 2 Miss J. Connal, General Hospital, Calgary; 3 Miss B. A. Emerson, 604 Civic Block, Edmonton; 4 Miss Phyllis Gilbert, 113 25th Ave. W., Calgary.

**British Columbia:** 1 Miss M. P. Campbell, 516 Vancouver Block, Vancouver; 2 Miss M. F. Gray Dept. of Nursing, University of British Columbia, Vancouver; 3 Miss M. Kerr, 946 20th Ave. West, Vancouver, B.C.; 4 Miss E. Franks, Ste. 5, Tudor Manor, 1035 Fairfield Rd., Victoria, B.C.

**Manitoba:** 1 Miss Jean Houston, Manitoba Sanatorium, Ninette; 2 Miss M. S. Fraser, Nurses Home, Winnipeg General Hospital, Winnipeg; 3 Miss A. E. Wells, 10-400 Assiniboine Ave., Winnipeg; 4 Miss M. Lang, 507 Walker Ave., Winnipeg.

**New Brunswick:** 1 Miss A. J. MacMaster, Moncton Hospital, Moncton; 2 Sister Corinne Kerr, Hotel Dieu Hospital, Campbellton; 3 Miss Ada Burns, Health Centre, Saint John; 4 Miss Mabel McMullin, St. Stephen.

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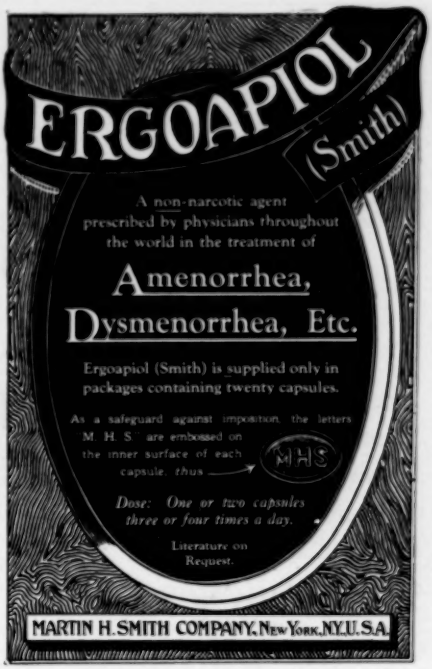
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